

University of Dundee

DOCTOR OF PHILOSOPHY

Middle-aged Lebanese women's construction of sexuality and sexual difficulties

A multiphase qualitative inquiry

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***Middle-aged Lebanese women's
construction of sexuality and sexual
difficulties: A multiphase qualitative
inquiry***

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Thesis submitted for the Degree of Doctor of Philosophy

University of Dundee

School of Nursing & Health Sciences

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Thank God for your gracious opportunity

'Life isn't about finding yourself. Life is about creating yourself'

George Bernard Shaw

'If we knew what we were doing it wouldn't be research'

Albert Einstein

'The price of success is hard work, dedication to the job at hand, and the determination that whether we win or lose, we have applied the best of ourselves to the task at hand'

Vince Lombardi

GLOSSARY OF TERMS

Heteronormativity	It is based on the belief that sexual activity is the only and natural expression of sexuality
Sexuality	It has a broad meaning and encompasses all the thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships
Sexual difficulties or problems	It is a discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience
Sexual dysfunction	It is described as disorders of sexual desire (motivation for sex), arousal (excitement in response to stimulation), orgasm (peak of sexual pleasure), and pain (pelvic or genital pain occurring before, during or after sexual act), marked with distress and interpersonal difficulties.
Sexual intercourse	It involves penetration of penis into the vagina
Sexual life	It relates to sexual relationships and activities
Sexual relationship	It refers to heterosexual relationships
Sexual-self	It is defined as an individual's evaluation of his or her own sexual feelings and actions

Table of content

GLOSSARY OF TERMS	03
ACKNOWLEDGEMENTS	21
ABSTRACT	25
CHAPTER I. INTRODUCTION	28
1.1. Background	28
1.2. Conceptualisation of sexuality	31
1.3. Biomedical conceptualisation of women's sexual difficulties ...	34
1.4. Social perspective on women's sexual difficulties	37
1.5. Rationale for the study	38
1.6. Aim and objectives	42
1.7. Structure of the thesis	44
CHAPTER II. LITERATURE REVIEW ON WOMEN'S SEXUALITY	47
2.1. Chapter overview	47
2.2. Definition of concepts	48
2.3. Scoping literature search	51
2.3.1. Introduction	51
2.3.2. Framework of the scoping review	52
2.3.2.1. <i>Formulation of the research questions</i>	52
2.3.2.2. <i>Identification of relevant studies</i>	54

2.3.2.3.	<i>Study selection</i>	56
2.3.2.4.	<i>Charting the data</i>	58
2.3.2.5.	<i>Synthesising and reporting the results</i>	59
2.3.3.	Reflection on the review	59
2.3.4.	Conclusion	65
2.4.	Historical overview of women's sexuality	67
2.4.1.	Sexuality and morality	67
2.4.2.	Sexuality from the Middle-Ages to the Victorian Era	69
2.4.3.	Early research on sexuality	72
2.4.4.	Social constructionist view of sexuality	74
2.5.	Sexuality in the Arab world and Lebanon	76
2.5.1.	Overview of the general situation in the Arab world	76
2.5.2.	Contemporary sexuality in the Arab world	78
2.5.3.	Overview about Lebanon	80
2.5.4.	Sexuality of women within the Lebanese context	81
2.6.	Contemporary understanding of sexuality	83
2.6.1.	Sexual socialisation and education	83
2.6.1.1.	<i>Role of parents</i>	84
2.6.1.2.	<i>Role of the school</i>	86
2.6.1.3.	<i>Role of the peers</i>	88

2.6.1.4. <i>Role of the media</i>	88
2.7. Gender-based sexual norms	90
2.7.1. Gender role and sexual double standards	90
2.7.2. Suppression of women's sexuality.....	91
2.8. Women's sexuality within the heterosexual relationship	93
2.8.1. Heteronormativity	93
2.8.2. Sexual desire within the heterosexual relationship	95
2.8.3. Orgasm within the heterosexual relationship.....	98
2.9. Sexuality and middle-aged women	100
2.9.1. Definition of the midlife/middle-age	100
2.9.2. Sexual functioning of the middle-aged women.....	101
2.9.3. Stigma around sexuality and ageing	104
2.9.4. Middle-aged women's sexuality in Lebanon and the Arab world	106
CHAPTER III. LITERATURE REVIEW ON SEXUAL	
DIFFICULTIES AND HELP-SEEKING	107
3.1. Chapter overview	107
3.2. Introduction	108
3.3. Prevalence of women's sexual dysfunction	109
3.4. Challenges related to the classification of women's sexual	
problems	113

3.5. Medicalisation of women's sexual problems	118
3.6. The new view of women's sexual difficulties	121
3.7. Help-seeking for sexual problems	123
3.8. Nurses' and midwives' role in sexuality-related care	125
3.9. Summary of the literature review	128
3.10. Comments on the review	130
3.10.1. Comments on the scoping review	130
3.10.2. Conceptual limitations	131
3.10.3. Methodological limitations	133
CHAPTER IV. METHODOLOGY AND METHODS	135
4.1. Chapter overview	135
4.2. Methodology	136
4.2.1. Theoretical framework.....	136
4.2.1.1. <i>Ontology</i>	137
4.2.1.2. <i>Epistemology</i>	137
4.2.1.3. <i>Social constructionism with a 'twist of pragmatism'</i>	138
4.2.1.4. <i>Qualitative research</i>	144
4.3. Methods	147
4.3.1. Study design	147
4.3.2. Study settings	149

4.3.3. Sampling	150
4.3.3.1. <i>Inclusion and exclusion criteria</i>	152
4.3.3.2. <i>Sample size</i>	153
4.3.4. Access and recruitment	154
4.3.5. Data generation.....	158
4.3.5.1. <i>Semi-structured, individual face-to-face interviews</i>	161
4.3.5.2. <i>Focus group interviews</i>	163
4.3.5.3. <i>Topic guide of the individual interviews with women: Phase I</i>	166
4.3.5.4. <i>Topic guide of the confirmatory focus group interview with women: Phase I</i>	168
4.3.5.5. <i>Topic guide of the individual and focus group interviews with women: Phase II-A</i>	169
4.3.5.6. <i>Topic guide of the focus group interviews with nurses and midwives: Phase II-B</i>	169
4.3.5.7. <i>Pilot- testing the topic guides</i>	169
4.3.6. Reflection on interviewing	171
4.3.7. Cultural transliteration of meaning	174
4.3.8. Data transcription	178
4.3.9. Data analysis	179

4.3.9.1. Familiarisation	182
4.3.9.2. Identifying a thematic frame	183
4.3.9.3. Indexing	184
4.3.9.4. Charting.....	185
4.3.9.5. Mapping and interpretation.....	186
4.3.10. Trustworthiness	187
4.3.10.1. Credibility	188
4.3.10.2. Transferability	189
4.3.10.3. Dependability	190
4.3.10.4. Confirmability	191
4.3.11. Ethical considerations	191
4.3.11.1. Qualitative interviewing and protecting vulnerability	193
4.3.11.2. Qualitative interviewing and autonomy/self-determination	196
4.3.11.3. Thick Descriptions and confidentiality	197
4.3.12. Researcher's concerns and safety	198
4.4. Conclusion	198
CHAPTER V: FINDINGS OF THE ANALYSIS IN REGARDS TO WOMEN'S UNDERSTANDINGS OF SEXUALITY AND SEXUAL DIFFICULTIES	200
5.1. Chapter overview	200

5.2. Description of the sample of women	200
5.3. Synopsis of findings	203
5.4. Women's understanding of sexuality	206
5.4.1. Women's sexual socialisation	206
5.4.1.1. <i>Unspoken and inhibiting sexual messages</i>	<i>207</i>
5.4.1.2. <i>Poor sexual information</i>	<i>212</i>
5.4.1.3. <i>Perpetuating the silence around sexuality</i>	<i>219</i>
5.4.2. Mute sexual self	223
5.4.2.1. <i>Frustrating sexual experiences</i>	<i>224</i>
5.4.2.2. <i>Contrasting sexual expectations and experiences</i>	<i>229</i>
5.4.2.3. <i>Middle-age and changing sexuality</i>	<i>243</i>
5.5. Women's sexual difficulties	248
5.5.1. Sexual unawareness and misconception	249
5.5.2. Deviation from normative assumptions about sexual behaviour	253
5.5.3. Quality of the relationship	258
5.5.4. Daily life events and stressors	263
5.6. Conclusion	266

CHAPTER VI. FINDINGS OF THE ANALYSIS IN REGARDS TO HELP-SEEKING FOR SEXUAL DIFFICULTIES	267
6.1. Chapter overview	267
6.2. Findings	267
6.2.1. Interpretation of the problem	268
6.2.1.1. <i>Significance of the problem</i>	269
6.2.1.2. <i>Lack of sexual interest</i>	273
6.2.2. Beliefs about help-seeking	275
6.2.2.1. <i>Stigmatising and intimidating</i>	276
6.2.2.2. <i>Informed choice</i>	281
6.2.3. Sources and quality of help	284
6.2.3.1. <i>The husband is the first source of help</i>	284
6.2.3.2. <i>The gynaecologist is the preferred professional</i>	287
6.2.3.3. <i>Unsatisfactory sexuality-related care</i>	291
6.3. Conclusion.....	296
CHAPTER VII. FINDINGS OF THE ANALYSIS IN REGARDS TO NURSES' AND MIDWIVES' PERCEPTIONS OF THEIR ROLE IN SEXUALITY-RELATED CARE	298
7.1. Chapter overview	298
7.2. Description of the sample of nurses and midwives	299

7.3. Findings	300
7.3.1. Perceptions of sexuality	300
7.3.2. Discussing women's sexuality	304
7.3.3. Muting women's sexuality	306
7.3.4. Coping with embarrassment	312
7.3.5. Promoting nurses' and midwives' role in sexuality-related care	316
7.4. Conclusion	318
 CHAPTER VIII. DISCUSSION OF FINDINGS OF THE ANALYSIS	
 IN REGARDS TO WOMEN'S UNDERSTANDINGS OF	
SEXUALITY AND SEXUAL DIFFICULTIES	319
8.1. Chapter overview	319
8.2. Introduction	319
8.3. Meaning of sexuality.....	324
8.3.1. Introduction	325
8.3.2. Sexual socialisation	325
8.3.2.1. <i>Inhibiting sexual messages</i>	326
8.3.2.2. <i>Poor sexual information</i>	330
8.3.2.3. <i>Perpetuating the silence around sexuality</i>	330
8.3.3. Mute sexual self	333
8.3.3.1. <i>Frustrating sexual experiences</i>	334

8.3.3.2.	<i>Contrasting sexual expectations and experiences</i>	335
8.3.3.3.	<i>Middle-age and changing sexuality</i>	339
8.4.	Sexual difficulties	347
8.4.1.	Introduction	347
8.4.2.	Sexual unawareness and misconception	349
8.4.3.	Deviation from normative assumptions about sexual behaviour	351
8.4.4.	Quality of the relationship	354
8.4.5.	Daily life events and stressors	355
8.5.	Conclusion	358
CHAPTER IX. DISCUSSION OF FINDINGS OF THE ANALYSIS		
IN REGARDS TO HELP-SEEKING FOR SEXUAL DIFFICULTIES		
AND NURSES' AND MIDWIVES' ROLE IN SEXUALITY-		
RELATED CARE		359
9.1.	Chapter overview	359
9.2.	Help-seeking for sexual difficulties	359
9.2.1.	Introduction	359
9.2.2.	Interpretation of sexual problems	361
9.2.3.	Beliefs about help-seeking	363
9.2.4.	Sources and quality of help	366
9.2.5.	Conclusion	370

9.3. Nurses and midwives role in sexuality-related care	371
9.3.1. Introduction	371
9.3.2. Perception of sexuality	372
9.3.3. Discussing women's sexuality	373
9.3.4. Muting women's sexuality	375
9.3.5. Coping with embarrassment	379
9.3.6. Conclusion	381
 CHAPTER X. CONCLUSION, IMPLICATIONS AND	
STRENGTHS AND LIMITATIONS	383
10.1. Chapter overview	383
10.2. Study contribution	383
10.3. Implications for education	387
10.4. Implications for practice	389
10.5. Recommendations for future research	392
10.5.1. Introduction	392
10.5.2. Research on sexuality	393
10.5.3. Research on sexual difficulties	395
10.5.4. Research on help-seeking for sexual problems	396
10.6. Strengths of the study	397
10.7. Limitations of the study	399

10.8. Concluding reflections	400
References	405
Appendices	469

List of Tables

Table one	Sources of recruitment of women	201
Table two	Distribution of women purposively by education level and menopausal status	202
Table three	Description of the sample of women	540

List of figures

Figure one	The different phases of the cross-sectional exploratory qualitative design	148
Figure two	Framework analysis of Richie and Spencer (1994)	181
Figure three	Framework of women's understanding of sexuality, sexual difficulties and help-seeking	205
Figure four	Framework of help-seeking for sexual difficulties	268

Appendices

Appendix one	Example of data charting of the scoping review about help-seeking behaviour for sexual problems	469
Appendix two	Information letter addressed to the administrators concerning women's participation in the study	494
Appendix three	Information letter addressed to the administrators concerning nurses and midwives' participation in the study	496
Appendix four	Topic guide of the individual interviews with women: Phase I	498
Appendix five	Topic guide of the confirmatory focus group interview with women: Phase I	501
Appendix six	Topic guide of the individual and focus group interviews with women: Phase II-A	505
Appendix seven	Topic guide of the focus group interview with nurses and midwives: Phase II-B	508
Appendix eight	Thematic framework of the data generated with women: Phase I	510
Appendix nine	Thematic framework of the data generated with women: Phase II-A	512

Appendix ten	Thematic framework of the data generated with nurses and midwives: Phase II-B	514
Appendix eleven	Example of overlapping quotes	515
Appendix twelve	Example of the thematic chart	516
Appendix thirteen	Example of data translation at the level of the thematic chart	519
Appendix fourteen	Example of the analysis process of the data generated with women	521
Appendix fifteen	Example of the analysis process of the data generated with nurses and midwives	525
Appendix sixteen	IRB approval forms: Phase I	527
Appendix seventeen	IRB approval form: Phase II	529
Appendix eighteen	IRB approval form of UREC	530
Appendix nineteen	Information sheet and informed consent form addressed to women: Phase I	531

Appendix	Information sheet and informed consent form addressed to	
twenty	women: Phase II-B	534
Appendix	Information sheet and informed consent form addressed to	
twenty one	nurses and midwives: Phase II-B	537
Appendix	Description of the sample of women	540
twenty two		

Publications from the study

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Azar, M., Baradbury-Jones, C. and Kroll, T. (2013) 'Patterns of help-seeking in women when problems arise in their sexual life: a discussion paper'. *Journal of Clinical Nursing*, 22, p. 3587–3596, doi: 10.1111/jocn.12374

Azar, M. (2011) 'Help-seeking Behaviour for female sexual dysfunction'. *Lebanese Journal of Nursing*. Special issue.

Unpublished manuscript

Azar, M., Kroll, T. and Bradbury-Jones, C. Sexual disclosure: Conformity to social taboos. It will be submitted to the journal of Culture, Health and Sexuality: An International Journal for Research, Intervention and Care.

Oral presentations

Azar, M. November 2016. Understanding Middle-aged women's sexuality. It was presented in the 2nd International Congress at Saint Joseph University, Faculty of Nursing Sciences, Lebanon.

Azar, M. (2013). Research proposal on women's understanding of sexual difficulties and the way their views are shaped. Post graduate student symposium, University of Dundee.

Azar, M. (2013). Middle-aged women perceptions of facilitators and barriers to help-seeking for sexual problems. Research Seminar at the University of Balamand, Faculty of Health Sciences, Lebanon.

Azar, M. (2012). Middle-aged women perceptions of facilitators and barriers to help-seeking for sexual problems. Post Graduate Student Symposium, University of Dundee.

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ABSTRACT

Introduction: This multiphase qualitative study explored the understanding of middle-aged women's sexuality and sexual difficulties and the way they address these difficulties. Nurses' and midwives' role in sexuality-related care was also explored. The need to address the subject was triggered by the multidimensional nature of female sexuality that could not be limited to one single definition; the medicalisation of female sexual problems that is based on the standards of sexual function and dysfunction; the scarcity of research that reflects on women's subjective views on sexuality and sexual difficulties and the way they address these difficulties. This is particularly crucial at the middle-age where women undergo hormonal and psychosocial changes that may affect their sexual life.

Methods: Interviews and focus group discussions were used to capture the narratives of 52 middle-aged women of 40-55 years in phases one and two of the study. They were chosen purposively by education and menopausal status from clinical and non-clinical settings regardless of their marital status and sexual orientation. Additionally, a sample of 11 nurses and midwives working in the hospital and primary healthcare centres participated in two focus group discussions.

Results: Women's narratives led to a comprehensive understanding of sexuality and sexual problems and the implications for help-seeking. Findings showed how women's interpretation of sexuality resonates within bio-psychosocial and cultural perspectives

driven by double standards and inhibiting sexual socialisation. Women's sexuality is 'muted', conflicting between frustrating experiences, personal expectations and the perception of sexual selves as affected by the middle-age and social myths. Yet, sexuality is central to women's life where they tend to play a sacrificing role and gain agency. Their sexual difficulties are multifaceted mirroring their inhibitions, relational conflicts, husbands' sexual problems and contextual burdens.

Women would firstly rely on their husbands to discuss together their common sexual issues as nobody can understand their needs more than both of them. In parallel, the gynaecologist is reportedly the first one they consult as they are familiar with him/her. Yet, some do not know who else to turn to for help. Women highlighted many personal, relational and contextual barriers to help-seeking focusing on their husbands' negative attitude. They also criticised the services offered and the lack of resources. Within this context and in focus group discussions, 11 nurses and midwives reflected on their attitude and behaviour towards sexuality-related care. They had opposing views concerning their involvement in the assessment of patients' sexual health and identified many barriers to having an effective role in the field.

Discussion and implications: This study has a unique contribution in voicing women's views and concerns as sexuality is underreported and poorly researched in Lebanon. Women's narratives shed light on many aspects of their sexuality, sexual difficulties and

the facilitators and barriers to help-seeking focusing on the role of nurses and midwives in this field. This comprehensive perspective that is contextually based has implications on education, clinical practice and research. It is particularly important to provide middle-aged Lebanese women with a culturally sensitive professional assistance to satisfy their sexual life. In addition, the publication of two papers from the study enriches knowledge in the field.

It is of note that in this study sexuality and sexual life are interchangeably used. Nevertheless, sexuality has a broader meaning and encompasses all the thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships (WHO, 2006), whereas sexual life is more related to sexual relationships and activities (Segen's Medical Dictionary, 2012).

CHAPTER I. INTRODUCTION

I.1. Background

The multidimensional nature of female sexuality was neglected until the last decades; probably because sexuality is too intimate and invisible (Paker, 2009). When it has been investigated, sexuality has largely been viewed in relation to biomedical models that have tended to overlook women's experiences and devalue their feelings and thoughts (Tiefer, 2001, a,b; Nicolson and Burr, 2003;). The attention was mainly devoted to male's sexuality whereby women were the focus of men's admiration and sexual satisfaction (Daniluk, 1993; Travis, Meginis and Bardari, 2000). In addition, little priority has been accorded to sexuality with ageing (Gott, 2006). The World Health Organization (WHO, 1978) asserts the individuals' rights to sexuality avoiding any discrimination of age, gender or health status. Sexuality is integral to human wellbeing throughout life (Kaschak and Tiefer, 2001; Hinchliff and Gott, 2008) and sexual health is a key indicator of the overall quality of life (WHO, 2006). Basson (2007) assumes that the improvement of mental state through the regain of sexual function might be one major aspect of the treatment of some chronic health problems among the elderly. Other authors consider sexual function as an indicator of successful ageing (Hart and Wellings, 2002; Katz and Marshall, 2003).

The contemporary view challenges the traditional stereotypes about sexuality and ageing, underpinned by sociocultural and demographic changes and scientific progress. In 1990,

the number of women at menopause and beyond was 467 million, among which 60% live in developing countries (WHO, 1996). By the year 2030, this population is expected to go up to 1200 million (WHO, 1996). With the growing population of women who enter the middle-age, more interest should be accorded by the professionals and healthcare system to their sexuality and sexual life. This period is characterised by many transformations that may have significant effects on women's sexuality and perception of their body image and attractiveness (Avis *et al.*, 2005; Dennerstein, Leherter and Burger 2005; Goberna *et al.*, 2009; Azar, Kroll and Bradbury-Jones, 2016). Many middle-aged and older women have the same sexual concerns as younger ones and remain sexually active throughout their lifespan (Gott and Hinchliff, 2003a; Guan, 2004; Nusbaum, Singh and Pyles, 2004; Addis *et al.*, 2006; Laumann *et al.*, 2006; Carpenter, Nathanson and Kim, 2009; Azar, Kroll and Bradbury-Jones, 2016). Women who perceive their sexual life as part of a satisfying quality of life would like to protect their sexual health (Kingsberg, Kellogg and Krychman, 2009). However, the place of sexuality in these women's life is regulated by social norms with the tendency to neglect their sexual needs with ageing (Kellet, 1991; Kessel, 2001). For instance, in a qualitative study by Agunbiade and Ayotunde (2012) in Nigeria, older men and women of 50–75 years concurred that sexuality is legitimate for older men but not older women. Otherwise, they lose their reputation as 'good women' as at an old age, they are expected to control their sexual desires (Agunbiade and Ayotunde, 2012). Similarly in Ghana, older women who have sexual intercourse are regarded as 'deviant' (Owusu and Anarfi, 2010). Even in Western

societies, older women are not always valued and sexuality and menopause are interpreted according to social expectations (Astbury-Ward, 2003). Whether women could be sexual or not depends on social judgment of their sexual thoughts, feelings and behaviour. In this way, women at middle-age and above are clouded by restrictive social norms whereas youthfulness is equated with attractive bodies and is idealised for sex life (Astbury-Ward, 2003; Azar, Kroll and Bradbury-Jones, 2016). The attempt to improve women's sexual functioning in middle and later life assuming that the improvement of sexual desire would relieve 'sexual dysfunction' engenders another complexity. This biomedical approach negates the multidimensionality of sexuality and encourages sexual medicalisation (Galyer *et al.*, 1999; Basson, 2001a; Bancroft, Loftus and Long, 2003; Tiefer, 2006a; 2012).

In order to demystify these sexual taboos and misconceptions, the biomedical, sociocultural, economic and political influences on women's sexuality should be deconstructed considering women's subjective views. Yet, this aspect of women's life remains largely unexplored (Tiefer, 2006a; Wood, Koch and Mansfield, 2006; Hinchliff, Gott and Wylie, 2012). Women's voice gives them the opportunity to conceptualise their sexuality using their own words, expressing their own thoughts and attitudes and ascertaining their individualised sexual experiences (Daniluk, 1993; Azar, Kroll and Bradbury-Jones, 2016). This supports the rationale for the present exploratory qualitative study on women's understanding of sexuality and the way they express their sexual life

and conceptualise sexual difficulties. This study sought to link women's views with the broad context of their sexuality; it was triggered by the absence of research inquiries about the topic in the Lebanese context.

1.2. Conceptualisation of sexuality

Sexuality is a complex phenomenon that is constructed and shaped by the interaction of the individual with sociocultural structures (Parker and Aggleton, 2007). According to Daniluk (1993, p. 1), 'For any individual, the construction of sexuality can be manifested in terms of gender appropriate sensing, feeling, knowing, and experiencing'. 'Sex is more than intercourse. It's more than physical. It's part of your personality. It involves all of you - body, senses, emotions, thoughts, memories, meanings, relationship' (Ogden, 2001, p. 20). This broad view implies the existence of different sexual realities (Parker and Aggleton, 2007) and experiential sexual meanings (Azar, Kroll and Bradbury-Jones, 2016). This multidimensional nature of sexuality renders it difficult to define and limit to one agreed single conceptualisation (Lavin and Hyde, 2006; Parker and Aggleton, 2007; Bellamy *et al.*, 2011).

Research on sexuality has been conducted underpinned mainly by the essentialist and constructionist epistemological views. These are presented in brief here and discussed in greater detail in the literature review in the next chapter. Up until the Middle-Ages, sexuality was articulated by religion (Foucault, 1978). In the late-nineteenth century, it

occupied the biomedical and sexology field (Foucault, 1978, Weeks, 1991) and was guided by the scientific view and empirical investigations (Weeks, 1991). Sexuality was identified as a human powerful nature independently of the social and cultural influences. In the 1970s - 1980s, this naturalness conception was disputed by the social science theorists and researchers, the feminist, the gay and lesbian movements and the HIV and AIDS epidemic of the 1980s (Gagnon and Parker 1995; Wood, Koch and Mansfield, 2006; Parker, 2009). The social construction of sexuality appeared in opposition to the biological reductionist approach, contesting its instinctive nature and framing it within a whole host of differing social and cultural contexts as well as political and ethical conflicts (Foucault, 1978; Weeks, 1993).

Sexuality research was mainly guided by the positivist [essentialist/biomedical] and the interpretivist/social constructionist paradigm (Creswell, 2002, cited in Aliyu *et al.*, 2014). Quantitative studies conducted among middle-aged women have mainly focused on the biological and hormones-related symptoms of menopause and the feelings associated with the 'empty-nest syndrome' and loss of reproductive capacities (McQuaide, 1998; Banister, 1999; Krychman, 2007; Ringa *et al.*, 2013). Overemphasis was placed on sexual activities and frequencies, sexual function and dysfunction and the efficacy of medical and pharmaceutical therapies (Addis *et al.*, 2006; Constantine *et al.*, 2015; Dennerstein *et al.*, 2015; Thomas, Hess and Thurston, 2015; Johansen *et al.*, 2016). Moreover, women at menopause and beyond are negatively portrayed in the media and pharmaceutical

references and described as old and sick (Kaufert and Lock, 1997; Berger and Forster, 2001; Bellamy *et al.*, 2011). Their sexuality is disease-oriented and their sexual difficulties are pathologised, perceived as a deviation from the 'natural sexual function' that is biologically defined (Wood, Koch and Mansfield, 2006).

The impact of hormonal changes and menopause on women's sexual functioning has not yet been well identified (Delamater, 2012). Findings vary considerably from severe to no-noticeable symptoms (Howard, O'Neill and Travers, 2006; Leiblum *et al.*, 2009) and from a decline to no-changes in the frequency of sexual activity (Koch *et al.*, 2005). In a review of population-based studies, Dennerstein and colleagues noted that '...hormonal change is only one aspect of the many factors that impact on sexual functioning' (p. 80) and that other factors such as '...stress level, physical and psychological health, and changes in partner status, as well as the woman's feelings towards her partner' (p. 80) should also be investigated (Dennerstein, Alexander and Kotz, 2003). Sexual functioning is multifaceted, affected by a multitude of biopsychosocial factors (Avis *et al.*, 2005; Dennerstein, Lehert and Burger, 2005; Goberna *et al.*, 2009; Khajehei, Doherty and Tilley, 2015). From a cross-cultural view, findings of the Study of Women Across the Nation (SWAN) reported differences in the frequency of sexual practices among African, Caucasian, Chinese and Japanese women residing in the United States (Cain *et al.*, 2003). The variability in women's sexual activity at midlife makes it reasonable to broaden research perspectives beyond the biological factors and explore how women's sexuality is affected

by the social context (Gannon, 1998). According to Dixon-Mueller (1993), 'sexuality has different meanings for different people in different contexts' (p. 6). Dillaway (2005) related the menopausal experience of women to the research paradigm assuming that this experience is positively viewed from a feminist stance and negatively from a biomedical one.

1.3. Biomedical conceptualisation of women's sexual difficulties

The contradictory thoughts about women's sexual function and dysfunction have opened a dialogue concerning the conceptualisation of women's sexual difficulties. Indeed, medicalisation of sexuality is a success in the field of sexual medicine and evidence-based practice; yet, it is criticised by the social science researchers, feminists and sexual therapists (Giami, 2009). It denaturalises women's sexuality and imposes a biomedical hegemony (Tiefer, 1996; Kaschak and Tiefer, 2001), marginalising the contextual factors as they are not scientifically evidenced (Bancroft, Loftus and Long, 2003; Tiefer, 2012). Sexual difficulties are classified as dysfunctional and amenable to medical treatment (Tiefer, 1996; Tolman and Diamond, 2001; Bancroft, 2002; Moynihan, 2003; Wood, Koch and Mansfield, 2006; Wood, Mansfield and Koch, 2007; Tiefer, 2008). This partially explains the high rates of sexual 'dysfunctions' that have been largely used to advocate for new treatments and advertise for 'sexuopharmaceuticals', influencing the public thoughts (Hartley and Tiefer, 2003; Moynihan, 2005). Pfizer's creation of the successful 'blue pill',

Viagra, for men was an incentive to look for a 'pink pill' for women (Bancroft, Loftus and Long, 2003).

A reflection on the epidemiological studies shows that female 'sexual dysfunction' is an indiscriminate widespread condition. It is perceived by women across cultures and age groups (Echeverry *et al.*, 2010), varying between 25.8 to 91 % (Khajehei, Doherty and Tilley, 2015) and negatively affecting their quality of life (Chao *et al.*, 2011; Tripoli *et al.*, 2011). Some examples of the literature show that the prevalence rates vary between 40-43 % in the United States (Laumann, Paik and Rosen, 1999; Shifren *et al.*, 2008); 41-54% in Britain (Dunn, Croft and Hackett, 1998; Mercer *et al.*, 2003), 32-51% in Iran (Safarinejad, 2006; Vahdaninia, Montazeri and Goshtasebi, 2009), 55 % in Canada (Gruszecki, Forchuk and Fisher, 2005) and 69% in Egypt (Elnashar *et al.*, 2007). In a comparative study of a representative sample of 45-55 year old women from Lebanon, Morocco, Spain and the United States, the percentage of 'sexual dysfunction' was the highest among Lebanese women and represented 59% (Obermeyer, Reher and Saliba, 2007). Bancroft, Loftus and Long (2003) warned for caution with these inflated rates. Their critical question was that 'When is a sexual problem a sexual dysfunction?' (p. 454), believing that a great proportion of these problems could be considered as 'adaptive or understandable reactions to current circumstances' (Bancroft, Loftus and Long, 2003, p. 205).

Female sexual dysfunction was defined in reference to the Diagnostic and Statistical Manual of Mental Disorders (DSM) that was adopted by the American Psychiatric Association (APA), based on Masters and Johnson's (1966) Human Sexual Response Cycle (Tiefer, 2006a). This approach has been criticised as it is genitally focused and symptom-based considering male and female sexual response cycles and sexual problems as similar (Tiefer, Hall and Tavris, 2002; Basson *et al.*, 2004). Although the DSM was conceived as a clinical guide that facilitates the researchers and clinicians work (APA, 2000), objective cut-off criteria between sexual function and dysfunction do not exist (Hendrickx, Gijs and Enzlin, 2013). The authenticity and validity of the DSM diagnostic criteria were subject to many inquiries like for instance a) the consistency, definition, classification and overlapping of criteria and dysfunctions (Leiblum and Nathan, 2001; Bancroft, Loftus and Long, 2003; Moynihan, 2005; Andreasen, 2007; Balon, Segraves and Clayton, 2007); b) whether to relate sexual dysfunction to a general or mental health condition although there is high evidence for the latter (Bodinger *et al.*, 2002); c) the course, frequency, duration and intensity of sexual dysfunctions (Mercer *et al.*, 2003; Balon, 2008); and d) whether distress should be considered (Oberg, Fugl-Meyer and Fugl-Meyer, 2004; Hayes *et al.*, 2006; Balon, 2008; Hendrickx, Gijs and Enzlin, 2013). The DSM-V (APA, 2013) has addressed many highlighted flaws and emphasised the biopsychosocial dimensions of women's sexual function.

The International Classification of Diseases reference, ICD 10, is another conceived guide to define sexual dysfunction and is widely used in research. It has also been criticised as it scored highest rates of sexual disorders in comparison to women's subjective perception of sexual problems (King, Holt and Nazareth, 2007). According to Tiefer (1995, as cited in Tiefer, Hall and Tavris, 2002), research studies based on 'problematic' diagnostic criteria are probably imbued with flaws.

1.4. Social perspectives on women's sexual difficulties

In response to the critiques of sexual medicalisation, a New View of Women's Sexual Problems Campaign was created in 2000 (Tiefer, 2001c). The aim was to fight against the biomedicalisation of sexuality and develop a new classification that focuses on women's identification of their sexual problems. These were defined as 'discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience' (Hartley and Tiefer, 2003, p. 49). The working group criticised the 'genitalisation' and stereotyping approach to sexuality, the overlooking of the psychosocial factors, the overdiagnosing of sexual problems and the increasing use of medications and iatrogenic procedures with inherent risks (Cacchioni and Tiefer, 2012).

The New View framed women's sexual problems within a biopsychosocial model composed of four categories: (a) sociocultural, political and economic; (b) partner and relationship; (c) individual psychology; and (d) medical or physical (Hartley and Tiefer,

2003; Tiefer, 2010). This classification situates women's sexual problems within a broad context where the individual's lack of sexual performance is the result of an inappropriate sexual socialisation, inhibition, marital conflicts or stressful burdens. It also shows the motives for sex relations that are not necessarily sexual like pleasing the partner or gaining agency. In this way, the root cause of sexual problems would be pointed out and counteracted. Within this large spectrum, women's sexuality is politicised in a way that the advocacy for sexual rights, sexual expression, sexual education and access to sexual health services without discrimination becomes a must. The New View promotes women's sexuality, anticipates sexual problems and proposes different types of psychosocial therapy without excluding the medical approach when this deems necessary. This large context that conceives sexuality as more than an immutable human nature challenges the biological approach that is closely linked with sexual medicalisation. It is expected that the introduced changes would reflect more accurately the proportions of women's sexual dysfunctions that inform strategic plan of actions to improve women's sexuality.

1.5. Rationale for the study

Presently, we have witnessed a boom of social research that investigates different dimensions of sexuality (Parker, 2009). This has opened a debate around many sexual and reproductive health issues, stirring up the moral, social and political instances that govern sexuality (Parker and Aggleton, 2007). The need to constructively respond to the

emerging challenges is constantly increasing (Parker, 2007), rendering sexuality one of the most debatable and deeply politicised topics in the twenty-first century (Parker, 2010). One of the crucial elements is to look at the factors that shape the construction of sexuality focusing on the socio-political and cultural processes and their junction with meaning and power. Many scholars and feminist researchers heeded the call for more qualitative research that captures the diversity of meanings and nuances that characterise women's sexuality (Tiefer, 2001c; Basson, 2002; Wood, Mansfield and Koch, 2007; Parker, 2010). Thus, many reasons justify the use of a qualitative research design for the current study.

Studies about sexuality are mostly quantitative and conducted in developed countries; many of them lack consistency and cultural sensitivity to allow for cross-cultural comparison. Studies are mostly developed among young populations considering sexual problems of the elderly integral to the ageing process, irreversible or untreatable (Berman *et al.*, 2003; Moreira *et al.*, 2005a). As the population is ageing and sexual activity has been associated with health benefits and longevity (Addis *et al.*, 2006; Hillman, 2012), the inquiry about women's sexuality is necessary. This is crucial after the childbearing years as women have fewer tendencies to highlight their reproductive and sexual health concerns (Magon *et al.*, 2012) and are more subject to health problems that affect their sexual function (Kralik, Koch and Telford, 2001; Fatemi and Taghavi, 2009; Julia and Othman, 2011; Webbera *et al.*, 2011).

Although sexuality has gained more attention on the health agenda, women's sexuality within this age group is often overshadowed by other reproductive health concerns like pregnancy, family planning and sexually transmitted infections (Gott and Hinchliff, 2003a; Gott *et al.*, 2004). Services in many ways do not meet women's expectations in that they often lack availability, accessibility and affordability (Moreira *et al.*, 2005a; Nicolosi *et al.*, 2006b; Feldhaus-Dahir, 2009; Maserejian *et al.*, 2010). Some health professionals lack the expertise; they do not recognise or discuss patients' sexual health as part of the health history and assessment (Matocha and Waterhouse, 1993; Dunn, Croft and Hackett, 1998; Sarkadi and Rosenqvist 2001; Haboubi and Lincoln, 2003; McGarvey *et al.*, 2003; Gott *et al.*, 2004; Bachmann, 2006; Harsh, McGarvey and Clayton, 2008; Zakhari, 2009). Furthermore, female 'sexual dysfunction' is still not clearly defined (Kingsberg and Althof, 2009) and not well addressed (Bagherzadeh *et al.*, 2010); recommendations or protocols about the way women might manage this condition do not really exist (Moreira *et al.*, 2008a). In parallel, the interest accorded to men's sexuality contributed to a significant improvement of male sexual health and overall quality of life (Kingsberg and Althof, 2009).

In the Middle Eastern countries including Lebanon, awareness about sexuality is steadily increasing, furthered by globalisation, the heavy impact of Western culture, mass media, communication technologies and social/policy reforms (Amado, 2004; Khalaf, 2006; Auwad and Hagi, 2012). This has promoted many Arab women's openness to talk about their sexual concerns without the fear of stigma or judgment (Khalaf, 2006). While

sexuality receives increasing attention in the public discourse, it has remained very much a taboo subject surrounded by mystery in the private sphere. Women's sexuality is particularly suppressed by social norms and is often overlooked (Khalaf, 2006; Auwad and Hagi, 2012). Sexuality and gender equality are inextricably coupled and highly politicised and regulated by double standards. Many reforms and feminist movements have advocated for women's sexual rights; yet women did not sufficiently benefit from these opportunities (Ilkharacan, 2008). They tend to engage in sexual acts as social/religious duties, out of a desire to have children and for socioeconomic favours rather than as a source of pleasure (Chamie, 1977; Elnashar *et al.*, 2007; Fahmy, El-Mouelhy and Ragab, 2010). The control over women's body and sexuality reflects one of the strongest indicators of patriarchal societies and gender inequalities (Khattab, 1996; Daouk, 2006; Khalaf, 2006; Ilkharacan, 2008). In comparison to the countries of the region, Lebanon is multicultural and considered to enjoy more liberal values. However, sexuality is still controlled by patriarchal and religious beliefs despite the new sexual discourses and openness that were reinforced by globalisation and social changes (Awwad *et al.*, 2013; El-Kak, 2013). Sexual research is scarce and the existing studies are mainly focused on reproductive health issues and menopausal symptoms.

To my knowledge, the current study is the first one that looks at women's sexuality in middle-age in Lebanon. Exploring the subject adds to the literature. The study is expected to be a step towards further openness in discussing sexual issues and empowering

women by giving them the opportunity to voice their sexual interests and concerns. Findings can inform researchers and professionals, particularly nurses and midwives, to intensify their research and clinical work about middle-aged women's sexuality. They can guide them to plan strategies in an interdisciplinary perspective to promote women's sexual well-being based on an individualised and comprehensive perspective. This approach is in line with the social constructionist epistemology that informs this study combined with a 'twist' of pragmatism.

1.6. Aim and objectives

This multiphase qualitative study explored the understanding of middle-aged Lebanese women's sexuality and sexual difficulties and the way they address these difficulties. It also explored nurses and midwives' role in sexuality-related care. The study was guided by the following research objectives that were to:

1. Understand how a sample of middle-aged Lebanese women describe and make sense of their sexuality as a sociocultural reality and how the construction of their sexuality varies across menopausal status, education level, religion and occupation.
2. Examine the difficulties women perceive in sexual life from their own standpoint and experiences and explore how these difficulties are shaped in relation to the male-centred sexual interactions and generally held views on women's sexuality and sexual difficulties.

3. Identify the facilitators and barriers to disclosing and help-seeking for sexual difficulties.
4. Explore the perceived role of nurses and midwives in the provision of sexuality-related care from the perspectives of women as well as nurses and midwives and identify the factors that affect this role.
5. Contribute to the body of knowledge in the field of sexuality and sexual difficulties of the middle-aged women, particularly in Lebanon.
6. Inform health professionals' practice in addressing sexual concerns and difficulties among middle-aged women and deliver sexuality-related care that is culturally sensitive.

1.7. Structure of thesis

Following this introduction, chapter two presents a scoping literature review focusing on women's sexuality, sexual difficulties and help-seeking. The chapter starts with some definitions; then presents a brief history of sexuality considering both Christianity and Islam, the two most common religions in Lebanon. The review explains how sexuality was affected by traditional thoughts, social, political, scientific movements and social science research from the Middle-Ages through the Victorian era, up till contemporary time. Sexuality within the Arab region and Lebanese context is also pointed out. Then, the social construction of sexuality is discussed reflecting on sexual socialisation, the heterosexual relationship, sexual functioning and sexuality at the middle-age and beyond reflecting on the case in Lebanon.

Chapter three discusses the epidemiology of sexual dysfunction based on DSM and ICD classifications and provides a closer exploration of the 'New View' definition of women's sexual difficulties. Then, help-seeking is briefly highlighted and a detailed explanation of this concept is included at the end of the thesis (Appendix nineteen) as a literature review paper that was integral to the generation of new knowledge within the PhD (Azar, Bradbury-Jones and Kroll, 2013). This is followed by an overview about the role of nurses and midwives in sexuality-related care. The chapter moves on to end with a discussion of the limitations of the review and the gaps identified in the existing literature.

Chapter four discusses the methodology and methods that guide the research questions. Within the methodology, the theoretical framework that underpins the study is explained and the rationale for this approach is justified. The methods detail the different steps of the research process. Then, the strategies used to design the sample, recruit participants and generate data using individual and focus group interviews are presented. The chapter moves on to reflect on ethical considerations, rigour processes and researcher's reflexivity. It ends with the plan of analysis guided by Framework with its five steps process (Ritchie and Spencer, 1994).

Chapter five, six and seven present with the analysis of findings generated with women and nurses and midwives, informed by the fieldnotes, personal reflections and the literature background. Chapter five addresses women's perceptions and experiences of sexuality and sexual difficulties and their multidimensional aspects, reflecting on descriptive and analytical data. Chapter six reports on the way women deal with their sexual difficulties, the facilitators and barriers to help-seeking and the sources and quality of help. Chapter seven outlines nurses' and midwives' experiences in dealing with the patients' sexual issues and the factors that affect their role in sexuality-related care.

The discussion of key findings of the study is split into chapter eight and nine and presented in light of the Lebanese context and the general literature. Chapter eight interprets the meaning of sexuality and sexual difficulties for women while comparing and

contrasting their differing views and in relation to other studies and contexts. Chapter nine discusses findings generated from the focus group interviews with nurses and midwives explaining their strengths and weakness in addressing patients' sexual concerns.

In chapter ten, a conclusion is drawn summing up the key findings and highlighting the relevance of this qualitative study and its contribution to knowledge.

CHAPTER II. LITERATURE REVIEW ON WOMEN'S SEXUALITY

2.1. Chapter overview

Sexuality has always occupied the literature and it has always been the center of interest of biologists, epidemiologists, artists, anthropologists, sociologists and psychologists to understand its divergent aspects and perspectives. The chapter starts with the definition of concepts followed by the scoping literature search. Then, it presents the literature review that provides a comprehensive understanding of the historical and social context within which women's sexuality is regulated and expressed.

The first section contains a synopsis of the history of sexuality in western societies, drawing on the different epochs. Then, the early research on sexuality follows presenting the work of researchers in the twentieth century that was mainly characterised by an essentialist view before witnessing the emergence of a broad perspective on sexuality influenced by the sexual revolution and feminist movements. The second section talks about sexuality in the Arab world and Lebanon and the way it is affected by patriarchal norms. The third section is about the contemporary understanding of sexuality as socially constructed. It focuses on the heterosexual relationship considering the feminist and social science researchers' views and debates around the subject. The fourth and last section of this chapter offers a literature about sexuality and the middle-aged women and

the stigma associated with ageing and sexuality. At the end, the available literature on sexuality of the middle-aged women in Lebanon and the Arab world is presented.

It is worth noting that the reviewed literature does not exactly fit within the context and epoch of the women of the present study since three to four decades ago, sex research was quasi nonexistent in Lebanon and is currently still sparse. Yet, an extrapolation from the international data is relevant to gain insight into the context in which Lebanese women receive sexual messages, symbols and values and develop their knowledge and capacities to voice and express their sexuality.

2.2. Definition of concepts

‘What is the history of sexuality a history of?’ asks Jeffery Weeks (1993, p. 21). This question is legitimate in every time and place. Robert Padgug (1979, p. 17) articulated that ‘Sexuality – the subject matter seems so obvious that it hardly appears to need comment... Yet, ironically, as soon as we attempt to apply the concept to history, apparently insurmountable problems confront us’. This difficulty probably stems from the nature of sexuality as well as its understanding which is constantly changing and subject to social interactions (Padgug, 1979) and competing discursive powers (Foucault, 1978). Sexuality could not be limited to its biological aspect, extracted from or seen independently of its context. Defining sexuality is one of the most challenging matters (Tiefer, 1991). Thus, sexuality is a wide concept that has different meanings and

interpretations and cannot be precisely conceptualised or confined to one single definition (Reiss, 1981; Tiefer, 1991). Therefore, although 'What is taken to be 'sexuality', what sex means, and what is meant by sex...is the issue' researchers often do not define sexuality and do not subscribe to a specific view (MacKinnon, 1987, p. 69).

For the purpose of this study, working definitions of sexuality, sexual health and sexual life have been adopted to provide a shared understanding. However, these concepts are not clearly differentiated.

The World Health Organization (WHO, 2006, p. 5) provides the following working definition: *'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles, and relationships.'*

While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors'.

An integrated component of sexuality is sexual health, defined as:

'A state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and

respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence' (WHO, 2006).

Sexual life is 'The directions and manifestations of the sexual drive that contribute to a person's life-style, sometimes confined to genital activity and sometimes referring to all of the manifestations of libidinal energy in the subject's personality and relationships' (Segen's Medical Dictionary, 2012). A more popular definition is that sexual life is 'a person's sexual relationships and level of sexual activity—ie, whether a person is 'getting 'it'', or 'doing 'it'' (Segen's Medical Dictionary, 2012).

In light of this broad conceptualisation, Daniluk (1998) described women's sexuality in a holistic perspective that encompasses all aspects of a woman's life including sex appeal, attitude, body language, relationships, emotions, intimacy and self perceptions, where the meaning ascribed to sexuality is influenced by sexual experience. The multidimensional nature of sexuality implies that individuals' traits and behaviours are contextual although they might be affected by the biological influences (Kelly, 2001). These views are in opposition to the essentialist definition of sexuality and align with social constructionism, adopted in this study. The proponents of this paradigm define sexuality as a social construct that is external to the individual (Delamater and Hyde, 1998). In this study, sexuality is viewed as more than having sex in terms of sexual activity. This perception

evokes a reflection on the inter-subjective meaning of sexual experiences and interactions (Parker, 2009). It also implies the way these experiences and interactions are regulated by social scripts (Simon and Gagnon, 1986) and the perception of sexual self within the sociocultural, political and economic influences (Giddens, 1992, cited in Alexander, 2008).

2.3. Scoping literature search

2.3.1. Introduction

The literature presented in chapter II and III was guided by two scoping reviews. A universal definition of scoping review and a consensus on the methodological approach and reporting do not exist (Levac, Colquhoun and O'Brien, 2010; Daudt, van Mossel and Scott, 2013; Colquhoun et al., 2014; Pham et al., 2014). The common one is that this method refers to mapping and synthesising the large literature, published and grey, quantitative and qualitative, pertaining to a certain subject (Arksey and O'Malley, 2005; Levac, Colquhoun and O'Brien, 2010; Gough, Thomas and Oliver, 2012). The scoping review is increasingly used to review health research (Davis, Drey and Gould, 2009; Peterson et al., 2016). It identifies the gaps about the explored topic and provides evidence that informs research, education, practice and policies in the healthcare arena (Arksey and O'Malley, 2005; Pham et al., 2014; Petersen et al., 2016). The scoping was appropriate for this study because human sexuality has been the subject of so many disciplines and study designs. It was also suitable to browse the limited sexuality literature available in the Middle-East and Lebanon.

The scoping review has been criticised as the studies are not included or excluded based on quality appraisal criteria (Levac, Colquhoun and O'Brien, 2010; Daudt, van Mossel and Scott, 2013; Dijkers, 2015). This approach is flexible and comprehensive and is not less rigorous than systematic reviews; however, the purpose is different (Pham et al., 2014). When appropriately conducted and thoroughly analysed and interpreted, the scoping review provides very valuable information (Davis, Drey and Gould, 2009).

2.3.2. Framework of the scoping review

In reference to Arksey and O'Malley (2005) and Levac and colleagues (2010), the review was guided by a well-defined methodology. This involved the elaboration of clear research questions, identification and selection of relevant studies, charting the data, synthesising and reporting the results.

2.3.2.1. *Formulation of the research questions*

The aim of the first scoping review was to identify the literature that informs the understanding of sexuality and help-seeking for sexual problems. The questions that guided the review were:

- What is the meaning women ascribe to sexuality?
- How is the meaning of sexuality constructed and shaped?

- What is known about help-seeking for 'female sexual dysfunction', what are the sources of help and what are the facilitators and barriers to help-seeking?
- What are the characteristics of the health professionals?

The initial scoping was focused on help-seeking for sexual dysfunction. With the emergence of the initial themes and familiarity with the literature, it was necessary to understand help-seeking as integral to the meaning women attribute to sexuality. So, this concept was added and extensively explored. The scoping was further expanded to include literature on the health professionals as their attitude and practice affect help-seeking.

Findings of the first phase of the study revealed that women's perception of sexual difficulties is male-related. The immersion in the literature supported this view. It also enhanced my awareness about the broad spectrum within which female sexual difficulties are constructed considering the physical, relational, social and cultural dimensions of women's sexual life. Prompted by this experiential reality and enlightened by the literature, the scoping review evolved in the second phase of the study to focus more in depth on women's sexual difficulties considering their multidimensional nature. The literature about nurses and midwives' involvement in sexuality care was also browsed in view of their essential role in the field. Adding to that, I often returned to the literature

to explore concepts that surfaced throughout the study like sexual violence, self-concealment and self-management.

The second scoping review was conducted with the aim to explore the literature about women's understanding of sexual difficulties considering their own views and experiences.

The following three questions were addressed:

- What is women's understanding of sexual difficulties and their related factors?
- How do women manage their sexual difficulties?
- What is the role of nurses and midwives in sexuality-related care and how is their role shaped?

2.3.2.2. Identification of relevant studies

The scoping process was flexible and not focused on a limited range of years. It was iterative and constantly updated with the progress of the study, from its conception to the conclusion to account for the most relevant and recent literature published up until 2016. The literature was sourced in different online databases. These included: Ovid MEDLINE(R), PubMed, Embase, CINAHL, PsycINFO, British Nursing Index, Science Direct (Elsevier), JSTOR, SCOPUS, Applied Social Science Index and Abstracts (ASSIA) and Google Scholar.

In consultation with the supervisors of the study, an expert on literature reviews and many librarians, a broad search strategy was established and refined to locate online references and identify the relevant literature. In the first scoping review, the search terms were selected to explore the diversity of references that encompass sexuality and help-seeking and identify studies that focus on women particularly at the middle-age and beyond. Where appropriate Mesh terms or subject headings or keywords related to the topic were used including sex, sexuality, sexual life, women, midlife, menopause, climacteric, ageing, elderly, socialisation, behaviour, attitude, meaning, understanding, perception, social construction, female sexual function, dysfunction, disorder, problems, difficulties, concerns, intercourse, help-seeking, treatment seeking, medical services, care, assistance, support, health professionals, counselling, sexual discussion, disclosure, Middle East, Arab, Lebanon. The keywords were entered separated and/or combined with Boolean operators as required in every database.

The search strategy of the second scoping focused mainly on sexual difficulties as it was the main concept explored in this review. The same databases were consulted using different terminologies and keywords to capture the literature about the subject. These were: women, menopause, middle-age, midlife, ageing, elderly, perception, meaning, understanding, experience, sexual concerns, problems, difficulties, dissatisfaction, sexual health, care, assessment, medicalisation, nurse, midwife, patient, Middle-East, Arab, Lebanon.

Alongside with the online key databases, the scoping was supplemented by relevant abstracts, commentaries, editorials, texts, reports, dissertations and books that were available in different libraries and websites. Many references were identified through the list of extracted articles. I referred to the 'Network of Arab Scholars on Sexuality and Sexual Health' and 'The Reproductive Health Working Group' to collect unpublished data available in the Arab world. I attended conferences and discussed different aspects of the topic with many specialised professionals like physicians, psychologists, anthropologists and sociologists who recommended additional references.

These additional resources helped me become more aware about the context within which the concept of sexuality evolved particularly within Lebanon and the Arab countries. Participants' accounts and the in-depth reflection on many aspects of their sexuality, debriefing and exchange with scholars, colleagues and lay people, men and women, were also enlightening and useful to build up the literature review throughout the different stages of the study.

2.3.2.3. Study selection

The literature was selected based on inclusion and exclusion criteria that were broad enough to provide a map of the available resources on the topic (Armstrong *et al.*, 2011). These criteria were discussed with the supervisors and updated to focus the review.

Inclusion criteria: The review included heterosexual women who are mainly at the middle-age; have different marital status; identify or not themselves with sexual problems; whether they sought or not a professional or any other source of help for these problems. The literature about health professionals including nurses and midwives was extracted irrespective of the field of work, specialty or demographic characteristics. All publications in English relevant to the study were retained and analysed. A few Arabic references were collected from the newsletters in addition to a few articles related to the Arab world written in French.

Exclusion criteria: Articles that address sexuality of specific subpopulations such as adolescents, sex workers and people diagnosed with physical or mental disabilities, substance abuse, sexually transmitted diseases particularly HIV/AIDS, acute and chronic health conditions were excluded as they were outside the scope of the study. Articles about clinical trials of hormone therapy for menopausal women, sexual orientation and male sexual dysfunction were similarly excluded.

No filters were imposed in terms of year of publication, study design or location. This enabled the examination of 'the extent, range and nature of research activity' (Arksey and O'Malley, 2005, p. 21) about women's sexuality and the development of a broad review. Full text articles that reported on the different concepts of the study were chosen based on the review of the titles and abstracts. Non-relevant material was removed according

to the inclusion and exclusion criteria. In an attempt to manage the broad scope of the review and facilitate the access to the information, the retrieved data were classified in different files and under different headings and subheadings. These mainly were: sexuality [construction, socialisation, culture, religious and non-religious views, relation/interaction, menopause, Arab world, Lebanon, liberation movements]; sexual health; sexual function [heterosexuality, desire/arousal, orgasm]; sexual problems/dysfunction [prevalence, related factors, classifications, medicalisation, new view conceptualisation]; help-seeking [types, sexual disclosure/discussion, facilitators, barriers]; health professionals [physicians, nurses and midwives, others].

2.3.2.4. Charting the data

Data were thematically charted considering the authors of the study, year of publication, location, aims, design, sampling, population, data collection, key findings, strengths, limitations and recommendations. As suggested by Armstrong and colleagues (2011), all or some of these categories might be investigated depending on the aim of the review. In this study, although the focus was on key findings, all the categories were considered to get different perspectives about the explored concepts. This rendered data management and synthesis complex especially with the emergent process of the study. The content of many articles was discussed with the supervisors particularly at the beginning of the review to gain confidence in doing this exercise and ensure rigour in the selection, assessment and critique processes. As the review comprises hundreds of references, only

an example of data charting was presented in appendix one to give evidence of the scoping review. It relates to the literature about help-seeking behaviour for sexual problems –including the articles about the health professionals–, a published paper (Azar, Bradbury-Jones and Kroll, 2013).

2.3.2.5. Synthesising and reporting the results

Data were analytically synthesised and structured around the main concepts of the study. These encompassed sexuality, sexual difficulties, help-seeking for sexual problems and nurses and midwives' role in sexuality care. Data provided a comprehensive literature review that was thoroughly discussed with the supervisors, critically revised and concisely reported in chapter II and III.

2.3.3. Reflection on the review

The scoping review provided rich information. In support of Levac and colleagues' (2010) views, it constituted a meaningful basis to a) refine the research questions; b) enlighten the elaboration of the topic guides; c) compare and support findings; d) take decisions and e) draw conclusions at the different steps of the study. It also allowed the identification of research gaps; thus inviting researchers, policy-makers and professionals to overcome them.

The number of included and excluded articles was not counted in view of the comprehensive literature review that was conducted at different points of the study. Many review rounds were applied and refined as it was impossible to determine at the outset all the parameters of the search strategy. Although numerical data are not presented, meticulous thematic analysis and synthesis were conducted, identifying the relevant results and main gaps. The review generated mainly empirical original studies identified in peer-reviewed journals. Some references were theory-based and others served for the elaboration of the history of sexuality and definition of different concepts. Quantitative designs exceeded by far the qualitative ones particularly in regard to sexual problems and help-seeking. The majority of the studies were published in the last three decades as women's sexuality has recently become the focus of the researchers. References identified in Lebanon and the Arab World where sexuality is underreported and tabooed were a minority in comparison to the wide scope of literature that originated from the Western countries. Combining qualitative and quantitative data that reflect on different cultures and cover many decades was a challenge to compare and contrast findings and draw conclusions. Thus, the interpretation was conducted in respect to the methodological and cultural variations.

Overall and in brief, almost all the articles included in the review identified the aims, sampling procedures, tools and methods of data collection and ethical considerations. However, some methodological details were missing particularly the plan of analysis in

many quantitative designs. In contrast, details on the analysis process and trustworthiness were noticeable in qualitative research; yet, data saturation was rarely mentioned. Many studies used population-based samples that were widely varied and representative while others had convenience and clinical samples that limited the generalisation of findings. In some cases, the participants were a mixture of men and women with wide age groups and different data collection tools and methods. These flaws probably alter the accuracy of findings as sexuality and sexual function vary in relation to the way they are measured and individuals' characteristics.

Reflecting on the main concepts of the review, it appears that the studies about women's sexuality emphasise the heterosexual normativity and sexual practice within marital life. Other aspects of sexual-self like emotions, intimacy, pleasure and orientation are out of sight particularly in the Arab world and Lebanon as the subject is taboo and politicised. Young women's sexuality has been the focus of the literature for many long years with little interest accorded to those at the middle-age and beyond. Although more research is emerging nowadays among this population, their sexuality is rarely addressed outside marriage. Research on premarital sex of adolescents' is more a priority issue as it is linked with risky sexual behaviour and sexually transmitted infections and HIV/AIDS. Knowing that the prevalence of the elderly who live alone is steadily increasing, women of this age group deserve more attention as many of them remain sexually active. Their sexual concerns should be considered and addressed.

Studies conducted in Western and developed countries tend to reflect liberate sexual thought and behaviour. They often portray women as open and easily acting upon their own sexual aspirations and needs. However, in Eastern and developing countries, studies present a stereotypical and submissive image of women particularly within Muslim societies. In many articles, the discourse concerning the Western and Eastern views often induces a cultural conflict that is depicted as linked to religion. As the construction of sexuality is contextual and affected by a myriad of political and sociocultural influences, it should be interpreted with caution and critical social perspective to avoid discrimination and generalisation. One universal definition of women's sexuality does not really exist. Some articles reported on women's agency and capacity to prove their sexual-self and balance their own needs with the imposed social norms.

The review also demonstrated that women's sexual problems are conceptualised differently by the research paradigms. From a quantitative perspective that guides the majority of the articles, these problems are rooted in the biomedical sphere and defined by the deviation from the biological sexual function. Menopausal women's sexuality is pathologised and linked to ageing and hormonal correlates whereas psychosocial determinants that accompany this physiological transition of women's life are overlooked. Often, women are labelled as sexually dysfunctional without being asked whether they are distressed or they see their situation as problematic. As different women have different

interpretations of their sexuality, their sexual function could not be evaluated arbitrary without the full consideration of their subjective views.

This partly explains the inflated prevalence of sexual problems. Up till now, there is no definite consensus on theoretically sound criteria concerning sexual dysfunction. A careful clinical evaluation that is individually based is warranted particularly at the middle-age and beyond. Women of this age group should not be regarded as sexually dysfunctional as their sexual interest has changed. Instead, their sexuality should be recognised and interpreted within the ageing process and life circumstances considering all aspects of sexual expression. Despite decades of research on the subject, the perception and experience of the middle-aged women is not sufficiently examined and a reductionist view is perpetuated.

Qualitative studies that counteract the biomedical classification of sexual problems are very few. A low rate of women volunteered to discuss the subject which potentially may induce a selection bias. The samples were generally small although they generated rich data. The interviews were conducted with women only although their sexual problems were reported as relational and male-centred; examining the views of both partners is warranted.

Although sexual problems are highly prevalent in the literature, help-seeking is poorly addressed. The models that explain this behaviour are missing; it is not clear why some women seek help and others do not when problems arise in their sexual life. The review about the topic is charted and presented in appendix one. It includes forty nine articles; forty seven original empirical studies; and two reviews. Seven articles, out of which two are qualitative, are about the health professionals as their knowledge, attitude and practice are closely linked to women's decision to seek help. Studies about help-seeking are in their majority guided by quantitative designs that primarily investigated the prevalence and correlates of sexual problems. This behaviour was often explored as an indicator of or attribute to these problems using predetermined and brief questions. This limitation was partly conquered by the minority of qualitative studies, five designs, that granted women the opportunity to express their views in a holistic approach.

Many findings are hypothetical as help-seeking is less likely to happen, thus the determinants of women's decision could not be fully understood. The participants were often chosen from clinical settings and probably more likely to seek help for sexual problems and talk about the subject. Women with other perspectives and different backgrounds may not be represented, limiting the generalisability of the results. Many articles lacked methodological accuracy and consistency and did not consider the sociocultural contexts of findings thereby restricting the comparison between groups. One example of these flaws is presented in the Global Study of Sexual Attitudes and

Behaviours [GSSAB] that was conducted in 29 countries. Despite the value of this study at an international level, the challenge of using the same data collection tools and procedures in different languages and cultures was apparent. This study explored the factors associated and not associated with help-seeking by two different sets of questions. Women who sought help were asked about the sources they relied on and those who did not do indicated why through a list of reasons. As such, the facilitators and barriers were not clearly identified in both cases. Furthermore, the outcome indicators of help-seeking are poorly addressed in the literature to improve the quality of healthcare services.

The literature about the health professionals provided substantial information about their lack of preparedness to address women's sexual concerns. Nevertheless, findings are mainly quantitative and do not sufficiently identify the wide range of conditions that affect their role in the field. Participation rates were low in view of the sensitivity and complexity related to the discussion of sexual issues. The samples were small and lacked variability and representativity in terms of sociodemographic characteristics and areas of work, which limits the generalisability of findings.

2.3.4. Conclusion

The scoping review generated an international literature about different aspects of women's sexuality with a past and current picture across countries and cultural groups. It shed light on this taboo topic and asserted the importance of sexual life throughout

women's life span. It highlighted the contextual and subjective meaning of sexuality and sexual problems in comparison with their biomedical conceptualisation and medicalisation, informing the current debate on how best to define these concepts. The review also revealed that the paradox between the high prevalence of sexual problems and low rate of help-seeking should be carefully interpreted as this relationship is not linear or straight forward. More evidence is required to understand the dynamics between the two elements as they are not exclusively mutual. The consideration of other factors including the health professionals' initiatives in supporting women to manage their sexual issues was reported as undeniable. Yet, their reluctance in the field was evident in the literature.

These key findings have implications on the promotion of women's sexuality. It is of first priority to conduct more research to better understand sexuality and sexual problems, help seeking dimensions and health professionals needs for training and awareness. It is also important to provide public health information and education and train the professionals to become more proactive and efficient in sexuality-related care.

2.4. Historical overview of women's sexuality

2.4.1. Sexuality and morality

Sexual morality is affected by religion in general but this review focuses mainly on the Christian-Islamic perspective as they are the predominant faiths in Lebanon. Historically, religion has had a great impact on sexuality. It has regulated people's sexual perception, attitude and behaviour by framing social morality and defining what is right, good and acceptable and what is wrong, bad and immoral. Clear boundaries have been drawn between sin and virtue and the body and soul (Hyde, 1994; Nye, 1999).

With Christianity, sexuality is considered a sin outside marriage; it is encouraged for procreation rather than recreation (Weeks, 1993; Nye, 1999; Mahoney, 2008). For a person to be virtuous, he/she has to renounce sexual desire and be driven by reason rather than passion and love (Grabowski, 2003; Soble, 2009). Saint Paul preached celibacy as a symbol of purity and a Christian ideal and Saint Augustine encouraged people to abandon their sexual pleasures (Bellioti, 1993; Grabowski, 2003; Soble, 2009). These views about sexual morality were also expressed by Saint Albertus Magnus and Saint Thomas Aquinas (Hillman, 2012). They have been transmitted throughout the ages and are still deeply embedded in Christian doctrines (Daniluck, 1993; Harper and Proctor, 2008).

Unlike Christianity that praises asceticism, Islam recognises the power of sexuality and attributes to it a sublime significance, encouraging sex as a source of pleasure and not only for procreation (Khattab, 1996). Mernissi wrote: 'We have seen that sexual satisfaction is considered necessary to the moral wellbeing of the believer. There is no incompatibility between Islam and sexuality as long as sexuality is expressed harmoniously and is not frustrated' (Mernissi, 1987, p. 113). Sexuality is only allowed within marriage; otherwise, it is adultery, fornication (Zena) that is subject to severe punishment (Bouhdiba, 1985). The Quran's call is for virtue and chastity.

'... and let those who find not the financial means for marriage keep themselves chaste, until Allah gives them means out of His grace...' (23:33)

Marriage is valued for the fulfilment of a religious duty within a heterosexual relation; the shari'a legitimises men's right to satisfaction and women's duty to satisfy him (Khattab, 1996).

Despite the divergence in Christian and Muslim views, El Saadawi (2007) concurred that in both contexts of patriarchy, women's sexuality is similarly oppressed. This view that is shared by the fundamentalists of the different monotheistic religions, either Christian, Jews or Muslim, is interpreted as a way to control women's sexuality since it threatens men's chastity and supremacy (Allgeier and Allgeier, 2000; Leo, 2005; Hunt and Jung, 2009). Patriarchal religions consider men's and women's sexualities as divinely different

(Rose, 1999). This refers back to the Old Testament where women (Eve) represent the flesh, carnal desire and act as temptresses of sexual pleasures that lead to negative consequences to humanity (Hawkes, 1996). This ideology reinforced the duality between men and women that was reflected in their daily life; men were seen as the brainpower and occupied in the public sector and women as emotional and wifehood (Lengermann and Niebrugge-Brantley, 2000; Leo, 2005). In the New Testament, Virgin Mary offered women the opportunity of salvation and purity (Hawkes, 1996). This evokes the duality of the Madonna/whore which depicts the duality of the sexy/conservative modern women (Kleinplatz, 2001).

2.4.2. Sexuality from the Middle-Ages to the Victorian Era

During the Middle-Ages, the Canon law was imposed across Europe and formalised religion held power over sexual thought and practice. Rules were imposed in the bedroom. Forms of non vaginal sex, some sexual positions and behaviours and same sex practice were condemned and their punishment varied according to the act and its frequency (Lochrie, McCracken and Schultz, 1997). Virginity and monogamy were essential. Chastity was prized for both men and women and the monastic life was privileged and was even widely spread within marriage between the two spouses. Semen was valued for procreative purposes. Having sex on Sundays, fast and feast days was forbidden (Karras, 2005). Sexual problems as well as organic problems of the female reproductive system were not recognised outside marriage as they were not considered

legitimate or justified. Nevertheless, an interest was accorded during this epoch to some aspects of women's sexual and reproductive health like sexual appetite, fertility, abortion and contraception (Martín, 2013).

An opposite view to the strictness on sexuality was marked by the existence of the lusty priests who used to seduce women during confession (Karras, 2005). These different sexual views and behaviours were gendered. Men's control over women's sexuality was common although female sexual pleasure was recognised considering women more sexually mature and get their orgasms more rapidly than men. In addition, sex was seen as doing it to someone else (Karras, 2005).

The renaissance era (14th-17th) was marked by more open and realistic sexual discourses and emancipation. Many philosophers and historians debated about the morality of sexuality and its regulation by the church as human beings are not only soul, but a mixture of reasoning, sensation and pleasure (Schiebinger, 1989; Hergenhahn, 1997). This new view was further developed during the 18th century and the time of the French Revolution, emphasising rationalism and objectivity and contesting the condemnation of sexual pleasure (Dean, 1996; Crooks and Baur, 2008). During this period, sexuality was politicised and constituted a symbol of power for the bourgeoisie and immoral for the working class women who were confined to domestic tasks and under men's dominance (Nye, 1999).

In the early 19th century, female sexuality was recognised from a medical view as multiorgasmic and essential for women's wellbeing (Fahs, 2007). Yet, this epoch showed a turnaround characterised by the sexual morality of the Victorian age that was inspired by the doctrine of the Church. Sexuality was prohibited and limited to procreation (Foucault, 1978). Innocence and sexual naiveté characterised ideal women, mainly those of the upper-middle class, who were devoted to their families (Mason 1994; Katz, 2005). Frigidity was seen as a normal attribute for women while sexual desire was associated to a mental illness (Fahs, 2007). Elizabeth Blackwell (1902), a Victorian feminist, advised the education of women to inhibit their sexual sensation considering it as shameful and masturbation as an evil that seriously affects women's health (Fahs, 2007).

In parallel, many writers like James Mill opposed sexual morality; he criticised the value of chastity imposed on women and called for equality between men and women (Mason, 1994). Another famous writer of that time, Jeremy Bentham, legitimised sexual pleasure independently of the institution although he prioritised sexual union within heterosexual marriage (Mason, 1994). Additionally, in his book *'Emile'*, Rousseau described sexuality as extrinsic and driven by cultural influences assuming that it is the imagination that stirs up the senses (Mason, 1994).

The twentieth century witnessed the emergence of research on sexuality, feminist movements and the essentialist and then constructionist views about sexuality.

2.4.3. Early research on sexuality

At the start of the twentieth century, the psychiatrist Richard von Krafft-Ebing, the author of '*Psychopathia Sexualis*' (1886) and the neurologist Albert Moll, the author of the '*libido sexualis*' (1889) introduced the notion of modern sexuality (Weeks, 1993; Oosterhuis, 2012). They described the different aspects of human sexual behaviours, shifting sexuality from the psychiatric understanding to a 'more general, autonomous and continuous sexual instinct' (Oosterhuis, 2012, p. 135). In his book '*The Psychology of Sex*', (1897), Havelock Ellis, a British sexologist, discussed the biological, historical and cultural aspects of sexuality and its normal and positive nature. He opposed childhood sexual inhibition, a source of women's sexual frigidity (Hawkes and Scott, 2005). He described men's and women's sexual desire as equal and only conceived sex within a heterosexual relation characterised by men's dominance and women's submission (Ussher, 1993;).

In the same vein, Sigmund Freud, a contemporary of Ellis, discussed the dynamic and multidimensional gender-based nature of sexuality, regarding men as active and women reactive (Hawkes and Scott, 2005; Fahs, 2007; Crooks and Baur, 2008). In the *Three Essays on the Theory of Sexuality* (1962), Freud described sexuality as instinctive and biologically driven, but affected by civilisation and culture; he distinguished between young girls' clitoral immature sexuality and older mature women's vaginal orgasm sexuality (Ussher, 1993). Both Ellis and Freud contributed to the current psychological perspectives of sexuality (Ussher, 1993; Hartmann, 2009). Contrary to Freud who

considered childhood development the result of sexual stages and that people are driven by sexual urges, the Neo-Freudian psychologists among others Alfred Adler and Carl Jung situated sexuality within the individual's moral, social and cultural context and interactions (Hawkes and Scott, 2005).

By the 1920's, this thought was further supported by the anthropologists like Margaret Mead who questioned the rigidity around sexuality and linked it with a broad perspective (Weeks, 1993). Alfred Kinsey, the father of sexology and a pioneer of sex research using scientific methods, reported on people's sexual behaviours. He published two books about *Sexual Behavior in the Human Male* (1948) and *Female* (1953). He freed sexuality of religious and social morality and perversions and placed it within a spectrum of individualised experiences. This has challenged the many existing beliefs and provoked religious and social criticism (Hawkes and Scott, 2005). Kinsey discussed women's capacity to orgasm and the diversity in their orgasmic responses privileging masturbation over intercourse. He rejected the orthodox link between the biological identity and sexual behaviour that is developmental and varies throughout life (Hawkes and Scott, 2005). His extensive research on sexual orientations contributed to the exclusion of homosexuality from the list of mental disorders set by the American Psychiatric Association (Gagnon and Parker, 1995). Despite the revolutionary views Kinsey introduced to sexuality, he was criticised for neglecting the context of the participants of his samples in examining sexual behaviours (Hawkes, 1996).

The studies of William Masters and Virginia Johnson (1966) were focused on normal sexual functioning and the physiological and psychological processes involved in the human sexual response cycle (Hawkes and Scott, 2005). Their model that comprised four phases (excitement, plateau, orgasm and resolution) served to frame sexual problems like women's frigidity and men's impotence and premature ejaculation (Tiefer, 2004; Crooks and Baur, 2008). Although their observations provided scientific evidence that enriched the discipline of sexology, Masters and Johnson were criticised because they did not sufficiently distinguish between men's and women's sexual functioning (Tiefer, 2004).

These researches were mainly biologically focused and guided by a heterosexual view that distinguishes the male and female 'nature' based on genetic and hormonal characteristics (Seidman, 2006; Malott, 2007). However, some authors contested this essentialist view and paved the way to the contextual understanding of sexuality considering women's feelings and experiences. Thus, the social constructionist theory emerged and provided insightful literature on the sociocultural context in which sexuality is expressed.

2.4.4. Social constructionist view of sexuality

New scholars regarded sexuality as a socio-historical construct that is acquired and learned rather than being purely biologically driven (Rubin, 1984; Seidman, 2003). This supposes that sexuality is a dynamic flexible process developed over time although it is a 'naturally primordial phenomenon' (Gagnon and Simon, 1973). In their work *'Sexual*

Conduct, the two authors suggested that sexuality might be the most socially malleable phenomenon as opposed to the most natural. In his book '*The History of Sexuality*' (1978), Michel Foucault emphasised the socio-historical construct of sexuality and contested its instinctive nature which is intrinsic to sexual organs or intercourse. Rather, he connected sexuality to other aspects of self and consciousness that are objectively identified and seen as independent of us.

With Weeks, sexuality was defined as 'a particularly sensitive conductor of cultural influences, and hence of social and political divisions ... sexuality has become the focus of ethical and political divisions' (Weeks, 1993, p.11). It is the product of negotiation and struggle based on cultural meanings and power relations rejecting a predetermined given or an 'inner truth'. Weeks also explained that sexuality has different meanings in different contexts where variety rather than uniformity is the norm. In the same vein, Rubin assumed that 'sexuality is as much a human product as are diets, methods of transportation, systems of etiquette, forms of labor, types of entertainment, processes of production and modes of oppression' (Rubin, 1984, p.157). Sex is understood as fundamentally social; it is affected by historical facts and inseparable of politics.

These views argue for flexibility when it comes to the interpretation and understanding of sexuality. The constructionist thought enables researchers today to look at sexuality from a socio-cultural lens that is more open to diversity and social reality.

With the reviewed western literature about the history of sexuality in mind, a brief synopsis on sexuality in the Arab world and Lebanon is presented.

2.5. Sexuality in the Arab world and Lebanon

2.5.1. Overview of the general situation in the Arab world

Similarly to other countries in the world, sexuality in Lebanon and the Middle Eastern Arab region is in flux (El Saadawi, 2007; Saad Khalaf, 2009). It is highly politicised and inextricably associated with gender inequality (Ilkcaracan, 2008). It is a taboo discourse (El Saadawi, 2007) regulated by dissonant moral codes (Khalaf, 2006). In her book, *'The Hidden Face of Eve'*, Nawal El Saadawi (2007), an Egyptian feminist, extensively reflected on the injustice against women describing them as victims of the patriarchy. Sexuality revolves around double standards and gender inequalities. This asserts the assumption that sexuality is entrenched in the social context and is less likely to be intrinsic to humans (Gagnon and Simon, 1973; Simon and Gagnon, 1999).

According to Djedidi (1973), the Arab language carries two distinct expressions that characterise men and reflect their dominance over women. 'Maleness' is equivalent to the biological sex and 'manliness' emphasises men's social dominance. However, femininity does not have any double terminology. In their article 'Sexuality in Contemporary Arab Society', Dialmy and Uhlmann (2005) noted that men's virility is regarded as their main social capital. Paradoxically, women's virginity and chastity are a must as they symbolise

the honour of the family and especially of its men. Quoting El Saadawi, 'There is a distorted concept of honour in our Arab society. A man's honour is safe as long as the female members of his family keep their hymens intact' (El Saadawi, 2007, p.47). Reflecting on the Iraqi society, Al-Khayyat (2009) noted that 'Girls are socialised to regard sex as predominantly a male concern; they are brought up to avoid any behaviour defined as sexual, such as dressing in a particular way, laughing or even walking freely, because an 'honourable' girl ought not to do anything which might lead men to desire her' (Al-Khayyat, 2009, p. 418). The author added that Iraqi women are in general ignorant before marriage and see themselves as dutiful to a man who has sex instinctively without love or consideration for their feelings and needs.

On the other hand, Ait Sabbah (1986) explained that Arab men are unconsciously afraid of women's sexuality qualifying it as insatiable. Women are implicated of distracting men from God's worship. Their desire is strong and challenges men's virility. Thus women's sexuality is a potential cause of threat to and discord with the social order and requires permanent control (Tucker, 1993). This legitimises the practice of female genital mutilation or circumcision that is still widely prevalent in many Arab countries like in Egypt, Sudan, Yemen and other countries in the Gulf (Fahmy, El-Mouelhy and Ragab, 2010). For example, in Egypt, the prevalence of this procedure was 91% among women of reproductive age in 2008 (the 2008 Demographic and Health Survey, cited in Fahmy, El-Mouelhy and Ragab, 2010).

Hind Khattab (1996) highlighted many 'positive' functions of this procedure as it a) consolidates feminine identity; b) reduces sexual desire, thus, preserving virginity, preventing masturbation and ensuring marital fidelity; c) embellishes the vagina and proves seductive to men; and d) provides better premarital preparation to satisfy the husband. It is absurd to find that female circumcision is encouraged and performed by women, reinforcing the violation of their rights as human and sexual beings.

2.5.2. Contemporary sexuality in the Arab world

In the contemporary societies, the patriarchal mentality has been challenged and the study of sexuality has evolved in the Arab world against a multitude of barriers. More than ever, sexuality constitutes a major source of ambivalence and contested morality between the new and old generations as well as proponents of conservative versus liberal beliefs (Joseph, 1994; Dialmy, 2000a, b; Khalaf, 2006; Saad Khalaf, 2009). Social values are moving towards sexual openness that is confronted with the traditional norms. 'The sexual realm, particularly in recent years, has been subjected to conflicting and dissonant expectations and hence has become a source of considerable uncertainty, ambivalence and collective anxiety' (Khalaf, 2006, p.7)

Obermeyer (2000) discussed the changing sexuality among Moroccan youth in light of the information technology and globalisation, which exposed them to both Middle Eastern and Western— often opposite – views. Christa Salamander (2004, cited in Khalaf and

Gagnon, 2006) also described the struggle of women in Urban Syria to stay chaste but attractive to have a wealthy marriage. Tunisian women reflected on the physical and psychosocial pressures they faced to meet the contrasting rural and urban definitions of beauty, body image, and sexuality (Foster, 2006). The increased age at first marriage has resulted in an increase of sexual activity outside marriage (Dialmy, 2000a; Ben Abdalla, 2010; Sieverding and Elbadawy, 2010). To satisfy their needs without compromising their future, women refer to all forms of non-penetrative sex or rely on subterfuges like hymen surgery before marriage (Sieverding and Elbadawy, 2010; El-Kak, 2013).

In the last decades, the efforts that address gender discrimination and to a certain degree sexual liberation have been opposed by the predominance of Islamic extremist voices, political instability and war-torn regions relegated the liberal reforms to a second level keeping few opportunities to promote women's sexual autonomy. As a result, in many countries, women were forced to wear the veil as a reinforcement of Muslim sexuality which opposes Western sexuality (Ilkcaracan, 2008).

Nevertheless, with the globalisation and modernisation effects, the feminists and civil rights movements combined with the sociodemographic changes, new sexual discourses and patterns of sexual behaviours have surfaced (Amado, 2004; Ilkcaracan, 2008; Sieverding and Elbadawy, 2010; El-Kak, 2013). An increasing number of activities have been designed to advocate against women's sexual suppression, honour killing, virginity

testing and female circumcision. These activities also aimed to promote sexual health, encourage sexual education and accept the non heteronormative sexuality like homosexuality (Amado, 2004; Ilkkaracan, 2008). The ongoing transformation of the Arab sexual thought and masculine view has been reported by Dialmy's (2000a) study suggesting that programmes of sexual and reproductive health contributed to the change men's masculine attitude.

2.5.3. Overview about Lebanon

Lebanon lies at the Eastern end of the Mediterranean Sea. It is a parliamentary democratic republic, which is constitutionally governed by a Maronite Christian president; the prime minister is Sunni Muslim and the speaker of the chamber of deputies is Shia Muslim. Lebanon is mainly composed of Christians and Muslims subdivided in 18 denominations. Relatively to the population size, which is approximately 4.5 million (Lebanon 2015 International Religious Freedom Report), Lebanon has the largest proportion of Christians among the Middle Eastern countries. Although Lebanon is one of the smallest countries in the Arab World, it is a major regional, cultural, educational, economic and health centre. Lebanon has also significantly participated in the formulation of the Universal Declaration of Human Rights (Chemali Khalaf, 2010).

Lebanon is recognised by its diversity and openness in comparison to the surrounding countries. It is known for its 'East meets West' mode of life; its culture is portrayed as

‘Arab coloured by Western influences’. It is multilingual and implicitly multicultural (Ayyash-Abdo, 2001, p. 505). Lebanon has strong tourism and international business. It is cosmopolitan, incorporating different patterns of lifestyles and mentalities that are attributed to the variety in its sociodemographic, cultural and religious backgrounds.

It is within this context that in the nineteenth and twentieth century’s, Lebanese women’s movements and coalitions, activists and writers emerged and flourished, voicing women’s rights to education, autonomy, access to work, fair treatment and gender equality (DeJong and Meyerson-Knox, 2011). Despite these efforts, many legislative decrees are still discriminatory and do not recognise women’s rights as equal to men. The political instability and insecurity that have reigned in the country for over three decades especially the 15 years of civil war, have taken over women’s efforts. Nevertheless, modern Lebanese women are highly educated, largely involved in the labour market, powerful and influential in many decision-making areas (Chemali Khalaf, 2010).

2.5.4. Sexuality of women within the Lebanese context

Despite all these developments, Lebanon is considered a conservative society, which is under the influence of strong religious beliefs and attitudes (Awwad *et al.*, 2013; El-Kak, 2013). Like many Arab countries, the Lebanese society is overwhelmed with ambivalence and contradictions (Khalaf and Gagnon, 2006).

In Lebanon, the age at first marriage, 32 years for men compared to 28.8 years for women, is the highest in the Arab region and one of the highest also in the world (Tutelian, Khayyat and Abdel Monem, 2006, cited in El-Kak, 2013). The implication of this biosocial gap was more tolerance towards premarital sexual activity which is in constant rise (El-Kak, 2013). Nevertheless, it is more practiced by men (73.3%) rather than women (21.8%) university students (Barbour and Salameh, 2009) confirming gender inequality and double sexual standards (Kahhaleh, El-Nakib and Jurjus, 2009; Awwad *et al.*, 2013). University women are afraid of social judgment and stigmatisation in case they do not respect sexual modesty (Daouk, 2006; Saad Khalaf, 2009; El-Osta, 2010). They struggle with the dual life, the one they desire and the one that is inflicted by the social order (Saad Khalaf, 2009). The factors that challenge young university women in the fabric of their own sexuality are expected to be more debilitating for middle-aged women. These were brought up during an epoch where the society was more conservative and less exposed to the effect of globalisation and modernisation. During that time, women had few opportunities for education. Thus, they are more economically dependent on their husbands and their activities are limited to household responsibilities and their role as spouses and mothers.

The following part discusses the international literature about the 'Contemporary understanding of sexuality'. This includes four subtitles which are: Sexual socialisation and

education; Gender-based sexual norms; Women's sexuality within the heterosexual relationship; and Sexuality of the middle-aged women.

2.6. Contemporary understanding of sexuality

2.6.1. Sexual socialisation and education

Sexual socialisation is the process through which the individual develops sexual knowledge, beliefs, attitudes, meanings, ethics and values (Gagnon, 1990; Longmore, 1998). The way women believe in the present did not happen in a vacuum. It is the result of what they acquired during the developmental milestones from childhood to adolescence to adulthood.

As highlighted by L'Engle and Jackson (2008), social attachment theories like social development (Hawkins and Weis, 1985), social control (Hirschi, 1969) and problem behaviour (Jessor and Jessor, 1977) relate individuals' conformity to traditional norms and values to attachment (e.g. parents and schools). Thus, adolescents who are more responsive to parents, schools and religious values are less exposed to permissive sexual thoughts carried by peers and media and are therefore, less susceptible to sexual behaviour (L'Engle and Jackson, 2008; Hoga *et al.*, 2010). According to some authors, parents are the first sexual socialisation agents followed by the school, peers and media (Chapin, 2000; L'Engle, Brown and Kenneavy, 2006; Pearson, 2008).

2.6.1.1. Role of parents

Parents' values and expectations about sexuality shape their children's sexual behaviour (Wamoyi, Wight and Remes, 2015). They often tend to transmit to their children what they themselves lived (Hoga, Alcântara and Lima, 2001). Several studies have shown that sexual socialisation is gender based and marked with complexity and timidity (Solomon *et al.*, 2002; Baumeister and Vohs, 2004; Kirkman, Rosenthal and Feldman, 2005; Hoga *et al.*, 2010; Hyde *et al.*, 2010; Bangpan and Operario, 2014).

Mothers are described in some studies as more open and supportive than fathers helping their children develop their self-confidence (Rosenthal, Feldman, and Edwards, 1998; Rosenthal and Feldman, 1999; Bangpan and Operario, 2014). However, Brock and Jennings (1993) described mother-daughter communication as negative focusing mainly on warning and conformity to rules. Solomon and colleagues' observations revealed that 'Parents and teenagers may desire openness; but in practice, they experience 'closed-ness'' (Solomon *et al.*, 2002, p. 981). Parents claim their openness whereas sexual talk is limited because of children's reticence pretending being sexually knowledgeable (Hyde *et al.*, 2010). Openness is also altered by children's gender (mother-daughter and father-son) and taboos around sexuality and is moderated by parents' poor knowledge and inappropriate attitude (Kirkman, Rosenthal and Feldman, 2005). For these reasons, British mothers and fathers did not identify with sex education role believing that the topic should be addressed in a formal way and by a professional who better know their

children's needs (Walker, 2001). 'Losing face' in front of their children was an additional major difficulty for the fathers of this same study. To avoid intimidating and embarrassing communication, parents push their children to rely on friends, books, church or nurses (Baier and Wampler, 2008; Hoga *et al.*, 2010).

Religious values at home are one major determinant of children's sexual attitude and behaviour (Thornton and Camburn, 1987). The family members who adhere to religious beliefs are more likely to have a conservative sexuality (Paul *et al.*, 2000; Méier, 2003; Manlove *et al.*, 2006; Visser *et al.*, 2007). Studies among adolescents and college students showed the same results (Fox and Young, 1989; Rostosky *et al.*, 2004; Brelsford, Luquis and Murray-Swank, 2011); thus, religiosity is a protective factor against risky sexual behaviours as it contributes to the delay of the first sexual intercourse (Rostosky, Regnerus and Wright, 2003). This makes sense as Biswas (2014) suggests that children who report their religious affiliation, grew-up in religious families. Religiosity also contributes to sexual double standards where sexual restrictions are more applied on the daughter rather than the son (Biswas, 2014).

Within the Lebanese society, parental sexual socialisation reinforces a silent, restrictive discourse carried by the mothers; yet, through their moral presence and position in the family, the fathers act as female protectors (Badawi, 2002-2003; Daouk, 2006; El-Osta, 2010). Badawi described the mothers' role with their daughters as 'intrusive and

persecuting'. This is illustrated by women's quotes: *'When I lost my virginity, after a sexual intercourse with my friend, it seemed to me I was hearing my mother's footsteps in the corridor, even though we were miles away from home and there was no way she could know what I was doing!'*. Another 24 year old girl asserts: *'I was so scared that my mother might find out that I was no longer a virgin just by looking at me walking around! She has always told me that a virgin had a different gait than a non-virgin!'* (Badawi, 2002-2003, p. 65).

2.6.1.2. Role of the school

WHO (1994) recommended sex education in schools that provides students with scientific information that helps them understand the multidimensional aspect of sexuality and stimulates their critical thinking to develop attitudes, make decisions and assume familial and social responsibilities. Actually, the WHO approach combines sexual education (knowledge and skills) with sexual literacy (use of skills based on knowledge to express one's thought, make decisions and solve problems) (Schneewind, 2001, cited in Shtarkshall, Santelli and Hirsch, 2007).

The discourse on sexual education that is provided at schools has always been controversial. It is a sensitive subject faced with the dilemma of what should be taught versus what should be prohibited. With the advent of the epidemic of the human immunodeficiency virus (HIV) in 1980, the need for sexual education that promotes sexual health was undeniable. Despite this, the subject is still imbued with political

conflicts between the conservative and liberal authorities in the East and West including Lebanon (Askew, 2007; Baydoun, 2008; Jackson and Weatherall, 2010; Yammine, 2011).

The tendency to advocate for abstinence-only programmes to prevent pregnancy and HIV infection neglecting the broader aspect of sexuality was opposed by many social science and feminists researchers (Allina, 2002; Rose, 2005; Tavris, 2008). Many studies have identified the positive impact of sexual education on sexual health outcomes (Kirby, Laris and Roller, 2005; Weaver, Smith and Kippax, 2005; Brugman, Caron and Rademakers, 2010). Another pitfall is that the programmes of sex education are mainly focused on biology overlooking the multidimensional nature of sexuality, its values and the different patterns of sexual behaviours (Shoveller *et al.*, 2004).

The situation in Lebanon is not different. A qualitative analysis of sex education sessions indicated that the content is focused on the anatomy-physiology of the reproductive system and the methodology lacks the interactive and argumentative approach (Yammine and Clément, no date). In addition, the programmes of sex education are not standardised; they vary from one school to another in regard to the content, students' age groups and religious background (Baydoun, 2008; Yammine, 2008; 2011). It is worth noting that the religious framework is strongly operative in the society fighting to sabotage sex education in schools (Badawi, 2002-2003; Baydoun, 2008). Currently, the Centre for Educational Research and Development and the United Nations Population

Fund are attempting in collaboration with the Ministry of Education to introduce a comprehensive sexual education programme to schools.

2.6.1.3. Role of the peers

Peers also influence each other and seek friends who have the same sexual attitude and behaviour (Brown, 1985; Baumeister and Twenge, 2002; Browning and Burrington, 2006). Peers of the same sex seem to be more influential on adolescents' female sexuality than peers of the opposite sex confirming the female control theory of women's sexuality (Baumeister and Twenge, 2002). Girls control each other's sexy and thin body image (Eder, 1995, cited in APA, 2011; Nichter, 2000). They tend to be sexually engaged just as far as their peers are to maintain conformity (Billy and Udry, 1985). Being in a group, girls refrain each other from having sex whereas boys support each others' ideas to have sex (Maticka-Tyndale, Herold and Mewhinney, 1998).

2.6.1.4. Role of the media

The media, in all its forms, presents women as sensual and sexy. It plays a major role in transmitting a provocative sexual culture that is condemned by parents (Hyde *et al.*, 2012). Media exposure contributes to more permissive sexual attitudes and behaviours (Wells and Twenge, 2005; Chia 2006; Zurbriggen and Morgan, 2006). Many studies have reported on the effect of the media in shaping and transforming sexual knowledge, attitude and behaviour (Shrum, 2002; Sutton *et al.*, 2002) and in influencing teenagers'

sexual behaviour (Gagnon and Simon, 1986; Kim *et al.*, 2007). For instance, a study by Greenberg and Smith (2002) revealed that adolescents who were commonly exposed to the media perceived unusual sexual behaviours as realistic. Messages emphasise men's sexual role that is oriented toward recreational sex and masculinity (Ward, 1995; Aubrey, 2004; Strasburger, 2006). Women are frequently depicted with a dismembered sexualised body, reinforcing the traditional messages of heterosexual relations and their submissiveness (Kilbourne, 1999; Wray and Steele, 2002). Zurbriggen and Morgan (2006) reported that college students who integrated these messages were more likely to see men as sex driven and in sexual competition with women. Reflecting on the distorting impact of the media, Kilbourne, (1999, p. 265) noted: 'When sexual jokes are used to sell everything from rice to roach-killer, from cars to carpets, it's hard to remember that sex can unite two souls, can inspire awe'.

The report of the American Psychological Association (APA) (2011) proposed that the media plays an important role in infiltrating sexualised portrayal of young and adult women. Offering comprehensive sexual education programmes was suggested to counteract the negative impact of the media and generate sexual thoughts and decisions based on information (APA, 2011).

The next section discusses the gender-based sexual norms that are entrenched in sexual socialisation.

2.7. Gender-based sexual norms

Men and women's sexual beliefs and behaviours are wrought by the cultural gender discrepancy since both of them are nurtured within different sexual codes and values fuelled by a historically patriarchal system (Blackwood, 2000; Baumeister and Twenge, 2002; Wells and Twenge, 2005; El-Saadawi, 2007).

2.7.1. Gender role and Sexual double standards

According to Billy Crystal, an American comedian and movie actor, 'Women need a reason to have sex. Men just need a place' (Fugère *et al.*, 2008, p. 169). Men and women are compelled to behave in congruence with social stereotypes (Rohlinger, 2002; Sanchez, Crocker and Boike, 2005) internalised since childhood (Oliver and Hyde, 1993; Hyde *et al.*, 2005; Connell and Elliot, 2009; Forrest, 2010). Different literature reviews conducted at different times supported the fact that although sexual double standards have been significantly declined, they still persist and influence the sexual behaviours of both men and women (Oliver and Hyde, 1993; Crawford and Popp, 2003; Fugère *et al.*, 2008). A meta-analysis of 30 published studies over two decades, 1981 to 2001, evidenced gender discrepancies mainly at the level of sexual freedom and the frequency, type, circumstances and context of sexual activities (Crawford and Popp, 2003). According to Lamb (2010), women's compliance with normative expectations at the expense of their own sexual desire and wellbeing is central to the control of female sexuality. The study of Reiss

(1986) across 186 cultures asserted this assumption; men's greater power was positively correlated with women's sexual suppression.

2.7.2. Suppression of women's sexuality

The suppression of women's sexuality was defined as 'a pattern of cultural influence by which girls and women are induced to avoid feeling sexual desire and to refrain from sexual behaviour' (Baumeister and Twenge, 2002, p. 167). Women-to-women sexual suppression is commonly reported (Oliver and Hyde, 1993; Millhausen and Herold, 1999; ElOsta, 2010).

Baumeister and Twenge (2002) assumed that based on the social exchange theory characterised by costs and rewards, women offer men sex and get in return material and moral gains. This probably explains the high prevalence of sexual suppression of women in patriarchal and low income countries and their long term engagement with men on whom they rely (Cacchioni, 2007). Findings from the Middle-East and Arab world including Lebanon further support the evidence that women integrate sexual power imbalance and comply with sexual duty as socially and religiously imposed on them. Yet, their motive to have sex might go beyond sexual desire and pleasure and have something to do with getting other benefits such as preventing the husband from engaging in extramarital affairs, desire to have children and for socioeconomic favours (Chamie, 1997; Guessous, 1997; Elnashar et al., 2007; Fahmy, El-Mouelhy and Ragab, 2010). Women acting dutifully and

avoiding an overt expression of their sexual desire might just be a strategy for them to gain power (Khattab, 1996; Wikan, 1996). This supports McKinnon's (1989, cited in Obermeyer, 2000) view that sex and power are closely linked and play on the advantages and disadvantages of women.

Thus, it would not be possible to prompt women to resist sexual suppression as long as they are not economically and politically supported. As argued by Baumeister and Twenge (2002, p. 199), 'Sexual liberation without political and economic liberation could leave those women in an even weaker position in society'. These women are probably in disadvantageous situations and are less likely to protect themselves from sexually transmitted infections, unwanted pregnancies and violence and are more likely to be frustrated and disinterested in sex (Gifford *et al.*, 1998; Go *et al.*, 2002; Badawi, 2002-2003; Maass, 2007; Ussher *et al.*, 2012).

Within the contemporary understanding of sexuality and gender roles, sexual double standards should be considered with new perspectives, promoting women as 'resilient actors, rather than passive victims' (Magar and Kambou, 2012, p. 86). Over time, women have become more open and men more permissive with studies reporting no or little evidence of sexual double standards (Sprecher, 1989; O'Sullivan, 1995; Feldman, Turner and Araujo, 1999; Shibley-Hyde and Durik, 2000; Marks and Fraley, 2005; Earle *et al.*,

2007). Meaning making about sexuality is socially constructed and constantly negotiated and changing.

2.8. Women's sexuality within the heterosexual relationship

2.8.1. Heteronormativity

According to some authors, sexuality is commonly perceived in terms of sexual orientation being heterosexual, homosexual, bisexual or any other non-heterosexuality (Gott, 2005; Bellamy *et al.*, 2011). Knowing that sexual orientation is developmental, it might vary throughout the lifespan, shifting from one edge to another (Burr, 1995). Yet, heterosexuality remains the legitimate socio-sexual frame where sexual intercourse characterised by the coitus or penetrative/penile sex with a stereotype pattern of 'foreplay, leading to intercourse, leading to orgasm' (Cacchioni, 2007, p. 300) represents the prime and privileged sexual standard (Gavey, McPhillips and Braun, 1999; Bogart *et al.*, 2000). Drawing on findings from men's and women's narratives, it seems that only coitus is perceived as 'real' sex conferring to it a biological nature with procreation purpose (Ingraham, 1994; Gavey, McPhillips and Braun, 1999; Carpenter, 2001). Women may consider penetrative sex as a proof of their female identity (Cacchioni, 2007); failing to perform it because of sexual pain engenders disappointing feelings (Kaler, 2006; Cacchioni, 2007).

The heteronormativity that is genitally focused has been subject to the feminist and social science criticism especially with the rise of the homosexual and bisexual movements (Ingraham, 1994). 'The more these critiques challenge the taken-for-granted concerning sex and gender, the clearer it is that current ways of thinking in sociology do not adequately account for sex variation' (Ingraham, 1994, p. 214). The normative view marginalises other kinds of sexual behaviours like kissing, touching, cuddling or oral sex. It constantly challenges men's and women's sexual performance and limits women's sexual preferences exposing them to submission, unpleasant sexual activities and sexual violence (McPhillips, Braun and Gavey, 2001; Khan, Townsend and D'Costa, 2002; Cacchioni, 2007).

Sexual violence defined by the fact of being forced to have sex or assaulted is widely reported in the literature of heterosexuality (Watts *et al.*, 1998; Watts and Zimmerman, 2002; Bostock, Plumptre and Pratt, 2009; Black *et al.*, 2011). It is affected by sociocultural and economic factors (Rhodes and McKenzie, 1998; Whyte, 2006; Rhodes *et al.*, 2010) and has negative consequences on women's physical, sexual, emotional and mental health (Garcia-Moreno *et al.*, 2006; Polis *et al.*, 2009; Rahman *et al.*, 2014). Sexual and gender-based violence constitutes a major public health and social problem (Garcia-Moreno *et al.*, 2006).

In Lebanon, although heteronormativity has been challenged by many homosexual movements, sexuality is still framed within the heterosexual marriage (El-Kak, 2013). Based on her clinical experience and research, Badawi (2002-2003) asserted that a small number of Lebanese women do not like vaginal penetration. People are socialised to act based on their social gender, perpetuating a misconception about normative heterosexuality. Marriage ceremonies to praise groom virility -through penetrative sex- and bride innocence remains in some societies particularly the Eastern ones, a must (Cindoglu, 1997; Obermeyer, 2000; Ilkkaracan, 2002; Dialmy and Uhlmann, 2005; Ilkkaracan, 2008).

2.8.2. Sexual desire within the heterosexual relationship

Laan and Both (2008, p. 510) noted that 'you don't have sex because you feel sexual desire, as the old drive model has it, but that you feel sexual desire because you have sex'. It is possible that women's sexual desire and activity are part of an iterative mutually reinforcing circle, which then is subject to additional influences that are physiological, social, cognitive and cultural. In this respect, Basson (2000, p. 52) wrote 'Women's motivation (or willingness) to have a sexual experience stems from a number of 'rewards' or 'gains' that are not strictly sexual, these rewards being additional to, and often of far more relevance than, the women's biological neediness or urge'. This means that women have less sexual urges than men and their response cycle is not linear; it is rather responsive than spontaneous, triggered in an emotional and caring relationship. Intimacy

affects the mutuality between marital satisfaction and sexual desire (Levine, 2002; Brezsnyak and Whisman, 2004; Graham *et al.*, 2004) and is inversely linked to sexual problems (Stulhofer *et al.*, 2005; Zhang and Yip, 2012). In support of these findings, women's narratives revealed that sexual exchange and the interest accorded by the partner increased their arousal (Graham *et al.*, 2004). They felt themselves desired and valued as the sexual relation was driven by love, attention and care rather than focusing only on penetrative sex.

In support of Basson's view (2000), some authors concur that the expression of sexual desire differs by gender (Leiblum, 2002) and that women have less sexual desire than men (Kadri, Alami and Tahiri, 2002; Nazareth, Boynton and King, 2003; Richters *et al.*, 2003). Others postulate that women have higher rates of sex avoidance or refusal and their sexual desire is more affected by a non-genital stimulation while men are more genitally focused and have higher sexual behavioural rates (Baumeister, Catanese and Vohs, 2001; Laan and Both, 2008).

With this in mind, a qualitative study suggests that sexual desire is dynamic and fluctuates from one context to another (Murray, Sutherland and Milhausen, 2012). This explains why some findings reported no change (Kleinplatz and Menard, 2007; Impett *et al.*, 2008) and others a decrease in sexual desire with the length of the relationship (Klusmann, 2002; Levine, 2002), describing sex as boring (Mollen and Stabb, 2010). Thus, the

assumption that sexual desire systematically decreases with time could not be generalised to all women. Narratives of women aged 26-40 years suggest that the decline of sexual desire within marriage is relational given the familiarity with the husband (Sims and Meana, 2010). Badawi (2002-2003, p. 62) wrote: '*Marriage and sexual satisfaction seem incompatible*'. This might relate to the different roles assumed by women as mothers, spouses and workers, leading to tiredness (McVeigh, 1997; Thompson *et al.*, 2002; Callahan, Sejourne and Denis, 2006; Sims and Meana, 2010).

Womanhood is commonly equated with motherhood emphasising sexual activity for the purpose of reproduction (Baker, 2005). Findings show that men and women perceive an incompatibility between motherhood and sexuality; being a good mother supposes having less sexual interest/desire and a woman who displays sexual interest is perceived as less likely to be focused on her maternal role (Friedman, Weinberg and Pines, 1998; Butcher, 1999). This view that is more common among men than women and among parents involved in active parenting than old parents (Friedman, Weinberg and Pines, 1998) asserts the stereotypical gender roles as assigned by the society. Furthermore, the challenges that relate to the reproductive life like the hormonal, physical and psychosocial changes that accompany the pregnancy, postpartum, breastfeeding and menopause overwhelm women. These changes alter their sexual desire and arousal, make sexual intercourse difficult and create a discrepancy between women's sexual desire and satisfaction and their partners' (Reamy and White, 1987; Avery, Duckett and Frantzich,

2000; Callahan, Sejourne and Denis, 2006; Trutnovsky *et al.*, 2006; Williams, Herron-Marx and Knibb, 2007; Frank, Mistretta and Will, 2008; Convery and Spatz, 2009; Bertozzi *et al.*, 2010; Chang *et al.*, 2011; Khajehei, Doherty and Tilley, 2012). Yet, feminists and social researchers believe that due to the cyclic and developmental changes in women's life, their sexual desire may accordingly vary which means that it is not inevitably less than men's (Tolman and Diamond, 2001; Leiblum, 2002; Peplau, 2003).

2.8.3. Orgasm within the heterosexual relationship

Closely equated with sexual satisfaction and partners' closeness and intimacy is orgasm, regarded as central to the heterosexual relation (Gavey, McPhillips and Braun, 1999; Potts, 2000; Nicolson and Burr, 2003). Trudel (2002) suggests that orgasm should be the focus of professionals as it is necessary for marital functioning. A qualitative study predominately composed of British young adults, (81%) women and (92%) heterosexual, pointed to the participants' conceptualisation of orgasm as the 'ideal and expected sexual pleasure' (Oppermann *et al.*, 2014, p. 511). For the majority, orgasm was framed in penile-vaginal intercourse that positions men as the providers of women's orgasm.

However, heterosexuality is incriminated in orgasmic difficulties that are more prevalent among women than men (Laumann *et al.*, 1994; Richters *et al.*, 2006). Coitus is equated with male orgasm (Braun, Gavey and McPhillips, 2003); however, it is a bonus for women (Roberts *et al.*, 1995) as men experience orgasm more often than women (Richters *et al.*,

2006; Galinsky and Sonenstein, 2011). The assumption is that women need other forms of stimulation to orgasm (Eschler, 2004; Fugl-Meyer *et al.*, 2006; Richters *et al.*, 2006). This opens the debate around women's orgasm whether it is clitoral or vaginal. A review of a large number of studies suggest that in addition to an adequate stimulation, sexual experience and age are other factors that affect women's orgasm (Simons and Carey, 2001). These studies have been critiqued for overlooking the women's psychosocial context which affects the outcome of their sexual behaviour (Meston *et al.*, 2004).

The intimate aspect of women's sexual life is as important as orgasm (Gavey, McPhillips and Braun, 1999; Ellison, 2001; Nicolson and Burr, 2003). Richters and colleagues (2006) concur that orgasmic difficulties mainly stem from the lack of adequate and sufficient stimulation during the heterosexual intercourse. Thus, women's failure to orgasm may imply men's incapacity to help them enjoy their sexuality; this reinforces the notion of women's passivity in sexual act (Potts, 2000; Nicolson and Burr, 2003).

Feminists and social researchers contest the conception of the gender power relation of heteronormativity that is focused on coital (Gavey, McPhillips and Braun, 1999) and orgasmic imperatives (Potts, 2000). The absence of orgasm, a mandatory ultimate step of scientific models of human sexual response cycle, is interpreted as a problem. Thus, the prevailing tendency is to pathologise women's orgasm rendering it subject to pharmaceutical and medical intervention as discussed later on (Tiefer, Hall and Tavis,

2002). Feminists and social researchers argue that women's orgasm should be interpreted from a cultural perspective.

The next heading focuses particularly on sexuality of the middle-aged women and how it is affected by the belief system and misconceptions.

2.9. Sexuality and middle-aged women

Women's sexual life becomes more critical at middle-age as it might be affected by ageing, hormonal changes and social prejudices. When women grow older, their sexuality is commonly associated with 'dysfunctionality', stereotype and stigma and is shrouded in secrecy (Ellis and Morrison, 2005; Sand and Fisher, 2007). Women might believe that sexual activity is not necessary or legitimate anymore since their ability to conceive is lost and bearing children at their age is socially undesirable (Shea, 2012). However, many older women remain sexually active and enjoy their sexuality as an essential component of their lifespan (Hinchliff, Gott and Ingleton, 2010).

2.9.1. Definition of the midlife/middle-age

The age at which one enters midlife or middle-age (both terminologies used interchangeably) is difficult to determine exactly. The estimation ranges between the late thirties and late fifties (Reynolds and Obermeyer, 2001; Hockey and James, 2003; Hashemi *et al.*, 2013) which probably corresponds to the menopausal period (Adler *et al.*,

2000). Hillman (2012) arbitrarily defined middle-age as the period of 40-64 years of men's and women's life. She classified this cohort of people as 'middle boomers', born from 1952 to 1958 (Hillman, 2012, p. 6). Empirical studies include midlife participants with a wider age group of 35 to 69 years (Fraser, Maticka-Tyndale and Smylie, 2004; Binfa, Robertson and Ransjo-Arvidson, 2009; Lodge and Umberson, 2012). Although midlife is considered based on a chronological age (Lippert, 1997), the most important is how the individual perceives oneself with ageing (Banister, 1999; Hillman, 2012). This large cohort of people who were exposed to socio-political and economic events, changing lifestyles, medical progress, invasion of the media, sexual revolution and civil rights movements, have their own thoughts, attitude and expectations concerning their sexuality.

2.9.2. Sexual functioning of the middle-aged women

Sexual functioning refers to one's ability to engage in sexual expression and sexual relationships that are rewarding, and the state of one's physical, mental, and social well-being in relation to his or her sexuality' (DeLamater, 2012, p. 127). Of particular interest is women's sexual functioning at midlife (Katz and Marshall, 2003; Winterich, 2003). This stage that is characterised by menopause, the physiological aspect of female ageing, is a complex event in women's life (Wray, 2007). It is marked by the cessation of the ovarian function, hormonal changes particularly the decrease in oestrogen, progesterone and androgen and the transition from reproductive to non-reproductive status (LeMone *et al.*,

2014). It is a period of adjustment to the physical and psychosocial challenges (Gonçalves and Merighi, 2009; Noonil, Hendricks and Aekwarangkoon, 2012).

With the growth of the old population, sexuality and ageing have been more investigated and have gained the attention of the public health and biomedical domains (Fraser, Maticka-Tyndale and Smylie, 2004; Fagulha, Goncalves and Ferreira, 2011; Magon and Babu, 2011; Noonil, Hendricks and Aekwarangkoon, 2012). Despite this progress, the subject is still ambiguous (Dillaway, 2005; Birnbaum, Cohen and Wertheimer, 2007). The relationship between sexuality and menopause is difficult to define and categorise in what is normal and successful or what is pathological and problematic (Gannon, 1998; Fraser, Maticka-Tyndale and Smylie, 2004; DeLamater, 2012). Thus, how sexuality is linked to ageing or vary as the direct effect of menopause is not universal even though the biological changes that alter this relation (Dennerstein, Dudley and Burger, 2001; Astbury-Ward, 2003; Dennerstein and Hayes, 2005; DeLamater, 2012).

A review of population-based studies revealed that the perception of sexuality at midlife presents great variability (Dennerstein, Alexander and Kotz, 2003). This suggests that sexuality and menopause are a dynamic social construct regulated by a belief system and social codes of attitudes and behaviours (Astbury-Ward, 2003; Parrado, Flippen and McQuiston, 2005). In their qualitative study on the heterosexual experiences of menopausal women, Hyde and colleagues (2011, p. 220) conclude that ‘...vaginal

dryness, often cited as a key impact of menopause on sexuality in biomedical literature, did feature in data, but relative to the wider contextual issues creating sexual qualms, it was a dominant issue in only a minority of cases'. In the same vein, the narratives of women aged 50 years and above reveal that sexual function does not necessarily decline due to menopause (Hinchliff and Gott, 2008). For instance, more than 75% of the middle-aged women of the 'Study of Women's Health Across the Nation' (SWAN) reported moderate to extreme importance of sex (Cain *et al.*, 2003) and others highlighted positive impact (Bachman *et al.*, 1985; Lodge and Umberson, 2012) or no change in sexual functioning with ageing (Dennerstein *et al.*, 1994; Deeks and McCabe, 2001; Koch *et al.*, 2005).

Psychological and sociocultural backgrounds and relationship adjustments to menopause have more impact on sexual functioning than the physical changes induced by hormonal decreases and menopausal status (Hawton, Gath and Day, 1994; Hartmann *et al.*, 2004; Avis *et al.*, 2005; Dillaway, 2005). Feelings, emotional wellbeing and interactions with the partners during intercourse are the strongest predictors of sexual functioning and health of pre, peri and post –menopausal women (Bancroft, Loftus and Long, 2003; Dennerstein, Leher and Burger, 2005). Responding to new obligations like taking in charge an elderly, caring for an ill family member, facing stressful life events like chronic illness, death, financial instability, changing employment, children leaving the household and having never had children were reported to negatively affect sexual functioning (Ballard, Kuh and

Wadsworth, 2001; Fraser, Maticka-Tyndale and Smylie, 2004; Birnbaum, Cohen and Wertheimer, 2007; Binfa, Robertson and Ransjo-Arvidson, 2009).

Sexuality of middle-aged and elderly women should be addressed within a multidimensional approach considering all the contradictions of powers that affect this relation.

2.9.3. Stigma around sexuality and ageing

It seems that the main challenge women face in their sexuality at the middle-age and beyond is their general and relational context which is largely stigmatising and imbued with criticism (Winterich, 2003). The lack of sex education, myths and taboo that associate midlife and older women's sexuality with prejudice render women less interested in and responsive to sex life. Many of them fail to enjoy sex; they are more likely to engage in sexual relation to satisfy the other (Gonçalves and Merighi, 2009; Yan *et al.*, 2011). They neglect their sexual life even though they are still in good health and commit themselves to a more conventionally accepted and socially valued role (Hansen *et al.*, 2004). Otherwise, they are stigmatised (Lichtenstein, 2008; Binfa, Robertson and Ransjo-Arvidson, 2009; Owusu and Anarfi, 2010). Narratives of menopausal women suggest that few of them are able to act on their sexual needs and discuss their concerns with their partners; women are not 'active negotiators' of their sexual agency (Wood, Koch and Mansfield, 2006; Hyde *et al.*, 2011). Stigma might affect both older men and

women; yet, women are more likely to apprehend ageing as it is equated with the loss of attractiveness (Slevin, 2010). This culturally constructed discrimination of sex and ageing partially explains why women's sexual life at midlife and later becomes more vulnerable than men's (Carpenter, Nathanson and Kim, 2006).

The media and pharmaceutical companies convey messages that reinforce a biomedical and pathological sexuality, incompatible with ageing (Kaufert and Lock, 1997; Berger and Forster, 2001). Women are often represented in a youth portrayal with conventional standards of attractiveness and stereotypical expectations. In parallel, older people are characterised as asexual (Hinchcliff and Gott, 2008) and the body image is seldom accorded a sexual representation (MacDonald, 1997; Berger and Forster 2001; Bellamy *et al.*, 2011). A content analysis of more than 4000 US movies revealed that only 13 of them represent the middle-aged women engaged in sexual activity (Weitz, 2010). Their sexuality is muted with a humourous rather than passionate character although in some cases women were presented in a romantic sexual engagement. In these films, sexuality is primarily attributed to slim, white and middle-class women and with 'age-appropriate' partner. Women who are unable to respond to these standards are disappointed (Burgess, 2004) and more likely to get psychological problems (low self-esteem and body image, shame, anxiety, depression) and altered sexual functioning (Fredrickson and Roberts, 1997; Banister, 1999; Murtagh and Hepworth, 2003; Sanchez and Kiefer, 2007; McKinley and Lyon, 2008; Weinberg and Williams, 2009).

Indeed, attitude vis-à-vis sexuality and ageing has changed in the contemporary society. But, to counteract the 'desexualisation phenomenon' of the middle-aged and elderly, the notion that sex is important for the individual health and wellbeing has been widely spread, further promoting the use of medication to remain sexually active (Butcher, 1999; Gott, 2005). This means as if there is no middle ground for the expression of sexuality of the middle-aged population.

2.9.4. Middle-aged women's sexuality in Lebanon and the Arab world

Studies conducted in the Arab world and Lebanon did not address sexuality and menopause per say. The main focus was on menopausal symptoms and their relation to the quality of life of women. Sexual function in these studies was explored as part of the biological symptoms of menopause and women's perspectives were not considered. These are highlighted in the next chapter that discusses the debate around the conceptualisation of women's sexual difficulties within the biomedical views and constructionist perspectives. The chapter also briefly discusses the role of nurses and midwives in sexuality-related care.

CHAPTER III. LITERATURE REVIEW ON SEXUAL DIFFICULTIES AND HELP-SEEKING

3.1. Chapter overview

This chapter is divided into three parts. The first one discusses the controversies in the conceptualisation of sexual difficulties. It presents the 'prevalence of women's sexual dysfunction' as classified by the medical diagnostic criteria, the 'challenges of the classification' and its pitfalls, the 'medicalisation of women's sexual difficulties' and the 'New View model' that contests the medical perspective and provides a multidimensional definition of women's sexual difficulties.

The second part of this chapter introduces the process of help-seeking for sexual problems. The literature review on this subject is detailed in the published article on the 'Patterns of help-seeking in women when problems arise in their sexual life: a discussion paper' (Azar, Bradbury-Jones and Kroll, 2013). Nurses and midwives role in sexuality-related care is also briefly highlighted.

The last part concludes the overall literature review by a reflection on the limitations.

3.2. Introduction

The understanding of women's sexual difficulties or problems largely lies within the biomedical discipline that is supported by Masters and Johnson's model of the Human Sexual Response Cycle (1966, 1970) which characterises women's 'normal sexuality' by the ability to orgasm via coitus. In the 21st Century, this model still serves as the bedrock for the definition of sexual dysfunction as outlined by the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, (American Psychiatric Association, 2000). This reference defines sexual dysfunction as disorders of sexual desire (motivation for sex), arousal (excitement in response to stimulation), orgasm (peak of sexual pleasure), and pain (pelvic or genital pain occurring before, during or after sexual act), marked with distress and interpersonal difficulties. The International Consensus Conference on Women's Sexual Dysfunction also recommended the inclusion of the distress criterion that might result from sexual difficulty (Basson *et al.*, 2000; *et al.*, 2004). In contrast, the World Health Organization International Classification of Diseases, ICD-10, defined sexual problems as the individual incapacity to engage in a sexual relation as he or she would wish without explicitly referring to the Human Sexual Response Cycle or personal distress and intrapersonal difficulty (WHO, 1994). As an alternative to these limitations, a New View model of women's sexual problems that is individual-centred was framed (Tiefer, 2001d) and the DSM-V (APA, 2013) introduced changes to overcome the gaps that exist in the literature and clinical practice.

In this thesis, the terminologies sexual disorders or dysfunctions are used as defined by the epidemiological study surveys and biomedical classification. Otherwise and within the context of the qualitative approach underlying this thesis, sexual difficulties or problems are being used as these terms encompass a broader perspective. The reason for this consideration is two folds. First, in the literature, there is no a clear and distinctive definition of the different terminologies. Second, I used sexual problems or difficulties rather than dysfunction or disorders to avoid labelling women based on a medical classification that ignores women's personal views and experiences of sexual function. The narrow definition of 'sexual dysfunction' is subject to debate and challenges (Tiefer, 2001b; Moynihan, 2003). Thus, sexual difficulties are considered in a wider perspective acknowledging women's views, interpersonal relationships and contexts and avoiding a medicalised approach.

3.3. Prevalence of women's sexual dysfunction

As mentioned above, this subheading reflects on 'sexual dysfunction' (rather than sexual difficulties) as conceptualised in the majority of the surveys by the biomedical criteria. Research evidences that sexual 'dysfunction' is highly prevalent affecting women in both developed and developing countries (Nicolosi *et al.*, 2004; Ishak, Low and Othman, 2010; Zhang and Yip, 2012). It represents a worldwide public health problem (Gruszecki, Forchuk and Fisher, 2005; Moreira *et al.*, 2005a) across cultures and age groups (Nicolosi *et al.*, 2004; Nusbaum, Singh and Pyles, 2004; Elnashar *et al.*, 2007; Obermeyer, Reher and

Saliba, 2007; Luftey *et al.*, 2009; Wallwiener *et al.*, 2010) and among women and men (Nicolosi *et al.*, 2004; Richters *et al.*, 2003; Træen and Stigum, 2010; Hendrickx, Gijs and Enzlin, 2014; Sathyanarayana Rao, Darshan and Tandon, 2015). Findings also suggested that the rate of sexual disorders is placed in a second rank after substance abuse in the psychology clinics and mental health care settings abuse (Wiederman and Sansone, 1999) and represents 50% of patients who receive psychiatry outpatient services (Wylie *et al.*, 2002).

The prevalence varies from one country to another, partly because of the confusion around the conceptual definition, diagnostic criteria and cultural variations. The 'Global Study of Sexual Attitudes and Behaviors' (GSSAB) conducted in 29 countries with 27,500 men and women aged 40–80 years evidenced that 49% of sexually active women have experienced at least one sexual dysfunction during the 12 months prior to the survey, ranging from moderate to severe (Moreira *et al.*, 2005a). Prevalence rates varied from 36% in Central/South America to 58% in East Asia and 46% in the Middle-East (Moreira *et al.*, 2005a).

Other studies conducted in the middle-East with varied samples of women reported one or more sexual problems with a prevalence rate ranging between 26-81.5% (Kadri, Alami and Tahiri, 2002; Cayan *et al.*, 2004; Safarinejad, 2006; Elnashar *et al.*, 2007; Loukid, Hilali and Bernis, 2007; El Shafie *et al.*, 2011; Jamali *et al.*, 2016). This prevalence varies with

menopausal status. In some studies, it increases with the transition from pre to peri and postmenopause (Gharaibeh, Al-Obeisat and Hattab, 2010; Rahman, Salehin and Iqbal, 2011; Abdelrahman, Abushaikha and Al-Motlaq, 2014; Bener and Farah, 2014). Yet, the study by El Shafie and colleagues (2011) suggests that sexual symptoms are more common among perimenopausal than pre and post menopausal women.

A comparative study conducted among a representative sample of women aged 45-55 years from Lebanon, Morocco, Spain and the United States did not depict an association between menopausal status and sexual symptoms; yet a positive association was identified with age (Obermeyer, Reher and Saliba, 2007). However, the prevalence of sexual symptoms (59%) was the highest among Lebanese women. Other studies that reported on menopausal symptoms indicated that sexual problems are the least prevalent (Gharaibeh, Al-Obeisat and Hattab, 2010; Sweed *et al.*, 2012). These low results might be explained by women's lack of understanding of sexual problems, timidity to report on sexuality, knowledge deficiencies about their sexual rights especially at an advanced age particularly when children have grown-up. This might explain the significant percentage of Jordanian women, more than half, who became sexually inactive after menopause, negatively affecting their relation with their husbands (Gharaibeh, Al-Obeisat and Hattab, 2010). Knowing that vaginal dryness commonly leads to sexual problems, the discrepancy between the two symptoms, vaginal dryness (18.9%) and sexual problems (4.3%), among

Egyptian women of 65-75 years is questionable (Sweed *et al.*, 2012). Beyond this age group, vaginal dryness was 54.41% however, only one woman reported sexual problems.

The different types of dysfunctions vary from one study to another. For instance, the lack of sexual interest/desire was the most commonly reported dysfunction in some studies (Nobre, Pinto-Gouveia and Gomes, 2006; Oksuz and Malkan, 2006; Derogatis and Burnett, 2008) while other studies highlighted mainly the inability to reach orgasm (Shokrollahi *et al.*, 1999; Ponholzer *et al.*, 2005) and vaginal dryness and painful intercourse (Dunn, Croft and Hackett, 1998; Mercer *et al.*, 2003). Among the Lebanese women, the change in desire represented the highest score 33 and 52% whereas pain with intercourse scored 13% and vaginal dryness 5% in both studies (Obermeyer, Ghorayeb and Reynolds, 1999; Obermeyer, Reher and Saliba, 2007).

Lo and Kok (2014) believe that orgasmic problems are more prevalent among Asian women and desire problems among Western women. The authors relate this divergence to the variation between the Eastern and Western culture, assuming that faithful Asian wives do not care about their sexual desire. However, they are more likely to report their inability to orgasm as they associate it with physical health problems. This is not the case of at least the Lebanese women of the two studies of Obermeyer and colleagues.

The variation in the prevalence and symptoms of women's sexual problems reflects their multidimensional nature. However, questions have been raised regarding the inflated numbers of these problems whether the reasons are methodological or related to the measurement criteria as defined by the 'Diagnostic and Statistical Manual of Mental Disorders' (DSM) and 'International Classification of Diseases' (ICD).

3.4. Challenges related to the classification of women's sexual problems

The Human Sexual Response Cycle model of sexual desire, arousal, plateau, orgasm and resolution constitutes the basis of the medical classification of women's sexual function. The model has been criticised for its linearity (Basson, 2001a,b) and for neglecting the non-vaginal sexual pleasure (Tiefer, 1991; 2001a). Within this model, the variation in sexual function is pathologised and interpreted as dysfunction while little importance is accorded to women's subjective experience (Bancroft, Graham and McCord, 2001; Tiefer, 2001c; Bancroft, Loftus and Long, 2003; Kendell and Jablensky, 2003; Moynihan, 2003; Graham and Bancroft, 2006). As such, sexual problems are considered like any disease or alteration of the physiological function where the diagnosis and treatment are standardised and applicable to all cases (Moynihan, 2005; Andreasen, 2007; Balon, Segraves and Clayton, 2007).

In clinical practice, there is often an overlap between the different disorders as a primary disorder might lead to a secondary one (Kingsberg *et al.*, 2013). Marked distress is a

central diagnostic criterion of the DSM-IV-TR. However, a study conducted with a sample of 35132 heterosexual Flemish men and women (aged 16 to 74 years) revealed that the overall estimation of sexual difficulties (without distress) is 23.3% for men and 39.9% for women. These percentages dropped to 11.3% for men and 20.2% for women when distress was considered (Hendrickx, Gijs and Enzlin, 2014). Other studies reported similar findings; the prevalence of sexual problems fell drastically when distress was included as a diagnostic criterion (Fugl-Meyer and Fugl-Meyer, 1999; Bancroft, Loftus and Long, 2003; Richters *et al.*, 2003; Hayes *et al.*, 2006; Shifren *et al.*, 2008; West *et al.*, 2008; Weiss and Brody, 2009; Træen and Stigum, 2010; Christensen *et al.*, 2011).

Another pitfall of the medical classification is that distress is a medical construct and may not correspond to women's language and understanding of their experience (Goldstein *et al.*, 2009). A validated measure of distress was suggested by the Third International Consultation on Sexual Medicine's Committee (Clayton *et al.*, 2010). In a focus group discussion, women experiencing difficulties in achieving orgasm were asked to respond to the question 'What one word would you use to describe your orgasm difficulties?' The term 'frustration' was commonly used to reflect their emotions (Kingsberg *et al.*, 2013). The study further confirmed the inappropriateness of the term 'distress' to represent what women with orgasmic difficulties might feel. This criterion is controversial unless it contributes to sexual difficulties (Oberg, Fugl-Meyer and Fugl-Meyer, 2004; Hayes *et al.*, 2006; Segraves, Balon and Clayton, 2007; Balon, 2008; Hendrickx, Gijs and Enzlin, 2013).

The inclusion of the relationship with the partner as another diagnostic criterion of sexual problems was not sufficiently documented (Beach *et al.*, 2006; Denton, 2007). Nevertheless, the relational context should be considered alongside with the personal traits and discrepancies between partners to avoid pathologising sexual function based on a comparative approach. Accordingly, the 'International Consensus Group on Female Sexual Dysfunction' recommended omitting the DSM criterion of 'marked distress and interpersonal difficulty' and instead including 'personal distress' (Basson *et al.*, 2000). For instance, having a discrepancy in sexual desire with the partner should not be assumed as a sexual dysfunction (Segraves, Balon and Clayton, 2007). Yet, it is questionable whether sexual desire should be considered as an individual trait or as part of the relationship construct (Clement, 2002).

Several panels have been organised to address the confusion in the medical classification of sexual problems, but a consensus on substantive changes was not reached. The reasons suggested by Segraves, Balon and Clayton (2007) are first the lack of empirical evidence to endorse changes and second the reluctance to include the subjective criteria for female arousal disorder to keep similarities in the DSM and ICD criteria concerning male and female diagnoses. This creates an additional limitation as the sexual functions of men and women are not similar (Basson, 2000; Laan and Both, 2008). Third, the DSM working group and task force members did not agree on the introduction of 'sexual satisfaction disorder' as a new criterion. However, Basson and colleagues (2000)

conferred that this category is a crucial motive for women to seek help for sexual problems.

In the preparation of the DSM-V and in response to the raised commentaries, a sub-workgroup concluded that 'it is time to carefully reflect on the evidence available to make the best scientific decision independent of industry, insurance, and health system concerns' (Binik *et al.*, 2010, p. 2386). Thus, the DSM-V (APA, 2013) abandoned the linear classification of sexual function and further emphasised the biopsychosocial perspective. A new category of criteria called 'associated features' was added. Factors included were 1) 'the partner's sexual and general health'; 2) 'the relationship'; 3) 'the individual vulnerability' (body image, history of bad sexual experience; psychiatric comorbidity, strains and hardship); 4) 'the cultural and religious norms and restrictions'; and 5) 'the medical conditions'. Male and female diagnostic criteria were set separately. A minimum duration of six months and a frequency of 75%-100% were added as diagnostic criteria for the majority of sexual dysfunctions. Dyspareunia and vaginismus were labeled 'genitopelvic pain/penetration disorder'. Sexual desire and arousal were merged into 'interest/arousal disorder'.

Although the DSM-V addressed many gaps of the medical classification of sexual problems, recent findings suggest that this new version might underdiagnose women with either sexual desire or arousal disorders separately (Hendrickx, Gijs and Enzlin, 2014).

Evidence concerning the high prevalence of women's satisfaction despite the low sexual desire (Graham, Brotto and Zucker, 2014) was ignored by the majority of the members of the 'Workshop on Female Sexual Dysfunction' held by the Food and Drug Administration (Tiefer, 2015). Another comment was that the definition of homosexuality needs further improvement (Sungar and Gunduz, 2014). Tiefer (2015) reflected on the adversarial atmosphere that governed the workshop and regretted the group members' incapacity and the unwillingness of some of them to grasp the opportunity of an evidence-based discussion to improve many areas of female sexual problems that are of major clinical importance. She said that 'It was a missed opportunity and a low point in the long struggle for women's sexual emancipation' (Tiefer, 2015, p. 603). Regardless, this version reflects research evidence more accurately than the previous ones despite the drawbacks that have been identified (IsHak and Tobia, 2013). More empirical studies are necessary to draw conclusions concerning its reliability in representing women's sexual difficulties.

The ICD-10 classification was also criticised for the confusion and overlapping in the diagnostic criteria (Basson *et al.*, 2003; Nazareth, Boynton and King, 2003; Basson, 2005) and the discrepancy between these criteria and women's own perception of sexual problems (King, Holt and Nazareth, 2007). These flaws will be addressed in the ICD-11 that according to the WHO (2014) will be published in 2017.

The overreliance on the biomedical classification leads to overdiagnosing and medicalisation of sexual problems.

3.5. Medicalisation of women's sexual problems

Medicalisation is 'a process whereby non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders' (Conrad, 1992, p. 210). It is the perception and management of social life events and behavioural problems from a biomedical angle, ignoring individuals' potentials to cope with these situations (Nye, 2003; Conrad, 2007). This process refers to sexuality as proper or perverse, normal or pathological, legitimising its control by expert medical professionals (Tiefer, 2012).

Setting up a normal way of having sex and imposing standards of sexual expression pathologises diversity (Potts *et al.*, 2004). In this respect, Segal stated that 'when sex is medicalised, then not having sex, or not having a particular kind of sex, can be pathologised' as sexual variation is deemed inadequate particularly when equating 'good sex' with 'good health' (Segal, 2012, p. 369). This means that having sex ensures good health and protects against diseases (Lee, 2010). In this way, medicalising sex becomes legitimate to maintain sexual activity despite all circumstances. Another aspect of sexual medicalisation is the cultural idealisation of women's body which problematises the embodied diversity, challenges women's perception of their body and affects their sexuality (Braun and Tiefer, 2010). The introduction of Sildenafil (Viagra) to the pharmaceutical market in 1998 to improve men's performance is another example of medicalisation of sexual function (Tiefer, 2000; Hicks, 2006; Tiefer, 2006b). This drug has

been efficient as a remedy for the physiological erectile disorder, but it has never been a solution for the multifactorial aspect of sexual problems.

The medicalisation and 'pharmaceuticalisation' of sexuality constitutes nowadays a major and complex health, sociocultural, political and moral debate (Cacchioni and Tiefer, 2012). This contemporary phenomenon occurs under the influence of a wide network and close alliances of medical professionals, academicians, researchers, politics, media and pharmaceutical agencies (Bancroft, Graham and McCord, 2001; Shaw, 2001; Moynihan and Cassels, 2005; Tiefer, 2008; Welch, Schwartz and Woloshin, 2011; Tiefer, 2012). It aims at a) pathologising the normal sexual function and negatively influencing its perception to justify a therapeutic indication; b) inflating the prevalence rates of sexual dysfunction by using diagnostic criteria that serve the underlying commercial purposes of the pharmaceutical industry; and c) encouraging the use of technology as 'risk-free-magic' (Tiefer, 2006b; Tiefer, 2010).

Ray Moynihan described female sexual dysfunction as 'the next big profitable disease' (Moynihan, 2005, p. 192). Thus, the media plays a crucial role in 'selling the disease' by portraying a condition as amenable to a drug intervention (Moynihan, 2005). The focus of the media on a particular condition is seen as health education and not a way to market a product. Being a medical journalist, Ray Moynihan was opposed by some women accusing

him of not admitting the existence of their sexual problems and their physiologic aspect as amenable to medical treatment (Moynihan, Heath and Henry, 2002).

Variability in sexual interest, orientation and expression across sociocultural context, age and gender is evidenced (Nicolosi *et al.*, 2004; Lippa, 2007). The attempts to set norms should be considered with caution (Potts and Bhugra, 1995). Sexual medicalisation is confined in a reductionist biomedical sphere while attempting to solve issues that are deeply rooted in the psychosocial and relational realm (Tiefer, 1996; 2004). This view is contradictory with the World Health Organization (WHO, 2006) definition of sexual health that focuses on a multidimensional non-medicalised nature of sexuality. It opposes human rights and women's liberation and autonomy to make their own choices as advocated by many feminists and social researchers.

As an alternative to sexual medicalisation, it was proposed to use a dimensional model that would prevent the categorical distinct boundaries between what is normal and abnormal sexual functioning. But this is still debatable as one model could not fit all cases (Widiger, 2005; Widiger and Samuel, 2005). The study of Sand and Fisher (2007) explored women's opinion about the model of sexual function that best represents their sexual experience. Women equally suggested each of the three models of Masters and Johnson (1996), Kaplan (1974) and Basson (2000), negating the presence of only one

sexual response pattern and calling for more diversity and openness to women's perception of their sexual problems.

Non-profit reform groups, feminists and social movements have fought against the sexual medicine industry through awareness campaigns, public talk, media advertising, lobbying, etc. (Freudenberg, 2005). Thus, the New View Campaign was established considering women's own views of their sexual difficulties (Tiefer, 1996; Tiefer, Hall and Tavis, 2002).

3.6. The new view of women's sexual difficulties

The New View Campaign convened in 1999 (Tiefer, 2008). It was composed of an interdisciplinary academic and activist group who worked on a theoretical framework centred on women's (and men) own definition of sexual difficulties. The New View Classification defines sexual problems as 'discontent or dissatisfaction with any emotional, physical or relational aspect of sexual experience' (Kaschak and Tiefer, 2001, p. 5). The model admits the following:

- the difference between men and women sexual function;
- the diversity in sociodemographic, cultural and political background which are important determinants of women's sexuality;

- the recognition of the importance of women's relationship in their sexual fulfilment and difficulties bypassing the focus on the physiological genital process of sex;
- the belief in the diversity in women's sexual desire, satisfaction and difficulties and uniqueness of sexual experiences, avoiding the uniformity and stereotypes.

The New View Group identified four interrelated domains that interfere with women's sexuality (Tiefer, 2001c). These are:

1. the relationship factors of the couples (distressing relation, stressful life events, discrepancies in sexual desire, likes and dislikes, no exchange and negotiation, unfavourable general and sexual health of the partner);
2. the psychological factors (history of abuse, personality disorders, mental health problems, sexual inhibition due to fear of sexual acts or of their possible consequences);
3. the socio-cultural, political or economic factors (knowledge deficiency, inhibitions due to personal and cultural conflicts and expectations regarding sexuality, social burdens);
4. the medical factors (poor medical conditions, pregnancy, medications, iatrogenic factors).

The integration of the New View classification constitutes a challenge for educators, researchers and clinicians to shape their approach according to a new conceptualisation, giving up the exclusive medical and pharmaceutical models. Nicholls (2008) who has empirically used the New View model, asserted its holistic approach considering it a '*valid alternative to the dominant DSM nosology*' (p. 524). The author suggested that contextual and mainly relational factors should be accorded first priority as they heavily affect women's sexual difficulties. Thus, the New View would serve to better diagnose and assist women with sexual difficulties. The model aligns with the current qualitative study that looks at women's sexual difficulties from a broad perspective to capture their multidimensional nature.

Facing sexual difficulties, women's decision to seek help is driven by many correlates and predictors that relate to their personal attributes, sociocultural factors and healthcare resources.

3.7. Help-seeking for sexual problems

Help-seeking is a complex and multifaceted process characterised by an adaptive behaviour whereby a person actively seeks assistance from an external source in response to a perceived need or problem that is not resolvable by his/her own resources (Koldjeski *et al.*, 2004; Mackian *et al.*, 2004; Baker, Olukoya and Aggleton, 2005). It is a daily life process that is expected to ensure satisfactory outcomes (Lee, 1999). Help-

seeking might be formal, relying on professionals, or informal, provided by the individual's network. Other informal sources of help may be anonymous and include books, magazines, Internet, etc. Help-seeking could be informational, therapeutic or emotional, depending on the situation expressed by the help-seeker (Andersen, 1995; Rickwood *et al.*, 2005).

Little is known about help-seeking for sexual problems. Lee (1999) proposed that 'while past research has focused on the factors predicting whether individuals request help when problems arise, little attention has been paid to how individuals request help' (p. 1473). The mechanisms that may explain why some women seek help for their sexual problems and others do not is not clear. A complex interplay of cultural and ethnic characteristics and structural factors affect people's willingness to seek help (Andersen, 1995; Unger-Saldana and Infante-Castaneda, 2011).

The literature abounds with theories and models that originate from different disciplines in an attempt to explain the help-seeking process. But, there is no consensus on a universal model that captures the multitude and complexity of factors that determine this behaviour (Gulliver *et al.*, 2012).

In an attempt to understand the subject, a review of a wide literature about help-seeking for sexual problems was conducted and structured around the 'information processing

model of the decision to seek professional help' (Vogel *et al.*, 2006). This model describes help-seeking as a four steps decision making process: 1) encoding, 2) generation and evaluating behavioural options, 3) deciding and enacting a selected response and 4) responding to peer and personal evaluation of the behaviour. Vogel's model addresses the individual interpretation of his/her environment and own capacity to respond to this environment considering the self-efficacy and social-cognitive theories. The use of Vogel *et al.*'s model (2006) to explain the factors that trigger or impede the help-seeking process for sexual problems provides a guide which could help the health professionals effectively assist women in their sexual needs.

To avoid redundancy, the review of the literature was presented in a published article entitled 'Patterns of help-seeking in women when problems arise in their sexual life: a discussion paper' (Azar, Bradbury-Jones and Kroll, 2013). The article is inserted at the end of the thesis.

Help-seeking for sexual problems may require a professional assistance that involves among others nurses and midwives.

3.8. Nurses' and midwives' role in sexuality-related care

The literature review about the professionals', particularly nurses' and midwives' involvement in sexuality-related care revealed their limited role and inconsistent

approach (Waterhouse and Metcafe, 1991; Gott *et al.*, 2004; Abdolrasulnia *et al.*, 2010). Women would like to rely on the professionals' assistance, but they lack self-efficacy to discuss their sexual issues (Berman *et al.*, 2003; Moreira *et al.*, 2005a; Brock *et al.*, 2006; Shifren *et al.*, 2009). Women's attitude is exaggerated by the professionals discouraging position (Wimberly *et al.*, 2006; Harsh, McGarvey and Clayton, 2008; Shifren *et al.*, 2009; Woolhouse, McDonald and Brown, 2014). Physicians, nurses and midwives neglect sexual health assessment and management in their daily practice although they are in direct contact with the patients and best suited to help them voice their concerns (Waterhouse and Metcafe, 1991; Matocha and Waterhouse, 1993; Haboubi and Lincoln, 2003; Bachmann, 2006; Harsh, McGarvey and Clayton, 2008). Yet, nurses assume that patients do not expect them to initiate sexual discussion or that sexual assessment is not a priority for an ill patient (Magnan, Reynolds and Galvin, 2005; Magnan and Reynolds, 2006).

Sexuality still carries considerable stigma for the professionals and remains a sensitive subject for discussion (Black, 2004; Mick, 2007). Barriers that have surfaced in the literature to explain professionals not addressing patients sexual concerns are: poor knowledge, embarrassment, anxiety, lack of confidence and training, fear of invading patients' privacy and inducing discomfort, limited resources, etc. (Fisher, 1985; Shuman and Bohachick, 1987; Haboubi and Lincoln, 2003; Solursh *et al.*, 2003; El-kak *et al.*, 2004; Magnan, Reynolds and Galvin, 2005; Bachmann, 2006; Magnan and Reynolds, 2006; Garcia

and Fisher, 2008; Abdolrasulnia *et al.*, 2010; Saunamaki, Andersson and Engstrom, 2010; Mansour and Mohamed, 2015).

Other barriers refer to the difference in the sociocultural and demographic backgrounds like gender and age differences, marital status, education, type of ward, specialty, work experience, race and ethnicity (Haboubi and Lincoln, 2003; Gott and Hinchliff, 2003b; Gott *et al.*, 2004; Hinchliff, Gott and Galena, 2004; Magnan and Reynolds, 2006; Burd, Nevadunsky and Bachmann, 2006; Hautamaki *et al.*, 2007; Abdolrasulnia *et al.*, 2010; Saunamaki, Andersson and Engstrom, 2010). For example, older age and higher educational level were associated with nurses having a more positive approach and experiencing fewer barriers in assessing and discussing patients' sexual concerns (Saunamaki, Andersson and Engstrom, 2010). Similarly, nurses who worked in the obstetrics/gynaecology units demonstrated more willingness to discuss patients' sexual concerns than other specialty nurses (Magnan and Reynolds, 2006). Nurses agreed that being knowledgeable and having enough time would prompt them to discuss the patients' sexual issues provided a private environment is secured (Moore, Higgins and Sharek., 2014; Mansour and Mohamed, 2015).

These obstacles that prevent the professionals from entering into a discussion with women would also discourage women to choose the professionals as their first help-seeking recourse. With women's lack of self-confidence and health professionals'

reluctance, sexual health assessment and management are overlooked. Moore and colleagues (2014) stated that regardless of their specialty, nurses should inquire about sexual health like any other topic. As part of the healthcare team, nurses and midwives should be sensitive to the significance of sexuality for women throughout life and help them seek help.

3.9. Summary of the literature review

In concluding, chapter II and III reviewed the literature on women's sexuality focusing on the western and Arab world.

The review provided a comprehensive understanding about sexuality throughout the past and current centuries. It presented its evolution as affected by the biomedical, historical, sociocultural and religious perspectives. The different aspects of sexuality were discussed in light of the opposing views between the narrow, medical conceptualisation and the broad, sociocultural perspective. The review pointed to women's sexual socialisation based on double standards and biological perspectives that reinforce men's power and women's submission. This view imposes norms of heterosexuality characterised by imperative vaginal coitus that was criticised by the feminist and social science researchers. Accordingly, desire and orgasm were viewed within a multifactorial context negating the linear sexual response cycle.

In the same vein, the review showed controversial findings concerning the frequency and intensity of physical change and sexual functioning of the middle-aged women. The variety of these findings was mediated by psychosocial and relational conditions. Stigma around sexuality and ageing was also discussed showing the biased and discriminatory messages that sexualise women and link their femininity with youthfulness and stereotypical portrayal.

Sexual difficulties were presented in light of the challenges of the biological classification and the tendency towards sexual medicalisation. The role of the 'New View' of women's sexual difficulties guided by the feminist movements and social science researchers was highlighted with a main focus on women's views and their biopsychosocial context. At the same time, the DSM-V abandoned its narrow perspective on sexual problems.

Then, the gap in the understanding of the help-seeking process was briefly discussed as more details are provided in a published literature review article at the end of the thesis. The role of nurses and midwives in sexuality-related care was identified focusing on these professionals' reluctance to address women's sexual concerns.

The chapter ended with a summary on the limitations of the review methodologically and conceptually.

3.10. Comments on the review

3.10.1. Comments on the scoping review

- The review was extensive as it included a broad spectrum of literature covering various major concepts that form the backbone of the study. Different theories and perspectives were examined to account for the complexity inherent to the conceptualisation of sexuality, sexual problems and help-seeking.
- The review has informed many decisions and supported the elaboration of the different steps of the research process. It gave me confidence in comparing and contrasting the different views within the Lebanese context and worldwide.
- However, the review was based on a scoping methodology and the quality of the articles was not appraised. This was necessary in view of the large scope of the study and the scarcity of sexuality-related research in Lebanon and the Arab countries.
- Studies conducted within these countries are mainly quantitative and focus on menopause. They are driven by a positivist stance. Believing that sexuality could not be understood without the consideration of history, society, culture, religion and politics, this approach reflects a limited perspective about women's sexuality.

3.10.2. Conceptual limitations

- The majority of the existing literature is quantitative and does not provide a deep understanding of women's sexuality. Qualitative studies about the subject are missing particularly in relation to sexual problems and help seeking behaviour. According to Tiefer (2001c), researchers may apprehend addressing 'real-life sexuality' because they are not comfortable with the topic; the use of questionnaires is less intimidating.

- Women's sexual function is mainly explored using medical criteria and cut-off points without concomitant clinical evaluation or considering women's own views. Poor association has been found between clinical and individual definition of sexual dysfunction (King, Holt and Nazareth, 2007). The categorical response possibilities used in quantitative studies provide information about frequency rather than what constitutes a sexual problem for women. A consensus on theoretical criteria that measure the subject does not really exist (Bancroft, Loftus and Long, 2003).

- Some studies used mixed samples of men and women and missed some important distinctions related to gender characteristics when measuring variables and analysing data. Knowing that many differences exist between both genders, this flaw results in an erroneous representation of women's sexuality.

- Sometimes, the sample is limited to a specific duration of the arising sexual problem excluding its distressing character; both criteria may affect the problem classification and the tendency towards help-seeking.

- There is a lack of well defined theories or models that underpin help-seeking behaviour for sexual problems and provide a comprehensive understanding of the factors that determine this behaviour. Often, identified variables are focused on personal characteristics of the individuals and or the healthcare providers and overlook the social context and the meaning people perceive in relation to the multifaceted aspect of this behaviour. The literature is not sufficiently concerned about how help-seeking evolves over time, circumstances and space and in relation to the healthcare system. The empirical evidence of certain models has been developed mainly in the fields of mental health and health prevention. Drawing on a comprehensive literature review, Azar and colleagues (2013) applied Vogel et al's information-processing model (2006) which constituted a unique contribution to the understanding of help-seeking for sexual problems. Future studies that are focused on women's insights are warranted to reflect the real-life sexuality of women. Overcoming these limitations would positively affect help-seeking behaviour and health outcomes.

3.10.3. Methodological limitations

- The literature abounds with epidemiological studies on sexual problems using clinic-based samples that are not representative as women have the tendency to not consulting a professional for sexual problems.
- Recruitment is sometimes limited to certain geographical areas and population characteristics. Age groups range from early adulthood to mature and elderly women. This variation should be taken into consideration since sexuality is age-related and is affected by women's maturity and perceptions which change during the different phases of their lifespan.
- Resource rich countries are more represented than resource poor countries; studies are mainly conducted in urban areas where people are supposedly more willing to discuss sensitive topics;
- Most of the selected participants are sexually active, married and heterosexual and other categories are neglected.
- Some studies reported low response rates due to women's reluctance to participate in interviews that discuss sexual issues. This may lead to sampling bias.

- Other methodological limitations relate to the lack of standardisation, the diversity in the definition of variables and measurement tools, the lack of consistency and rigour in the data collection procedures and the translation processes, the absence of respect for cultural sensitivity, etc. This leads to inaccurate findings that do not permit reliable conclusions (Bancroft, Loftus and Long, 2003; King, Holt and Nazareth, 2007; Christensen *et al.*, 2011).

- Classification errors should be considered since the majority of the measures are self-reported. Hence, participants may not be aware about the sexual condition, forget to mention it, or report socially desirable or non stigmatising responses.

- All these methodological flaws make cross-cultural comparisons very challenging (Dunn *et al.*, 2002). For example, the 'Global Study for Sexual Attitude and Behavior' which drew samples from 29 countries using the same questionnaire contributed to a cross-national understanding of the cultural, socioeconomic, contextual, and health factors that relate to women's sexual problems and help seeking behaviour. Nevertheless, this study used different sampling methods. Data were collected in different ways according to country facilities and accessibility of participants. The instrument used to collect data was not necessarily culturally sensitive to all the 29 countries. The response rates were modest but assumed by the authors to be representative of the surveyed populations.

CHAPTER IV. METHODOLOGY AND METHODS

4.1. Chapter overview

This chapter is subdivided into two parts. The first one is the methodological approach which discusses the underpinning theoretical framework that guides the study. The methods form the second part; it describes the empirical approach which means the different procedures, tools and techniques that served to generate and analyse data and to answer the following research questions:

1. How do middle-aged women perceive and make sense of sexuality?
2. What informs women's sexual views and experiences and how does the construction of sexuality vary in relation to their menopausal status, level of education, religion and occupation?
3. How do women describe their sexual difficulties and what are the factors that affect their sexual activities and interactions?
4. What are the barriers and facilitators that women identify in relation to seeking help for sexual difficulties?
5. What are the different sources of help and the preferred characteristics of the helpers that women consider important in managing sexual difficulties?
6. Do nurses and midwives perceive that they have a role in sexuality-related care and how do they practice this role?

7. How are nurses and midwives' roles affected by their personal experiences and the healthcare system?

4.2. Methodology

4.2.1. Theoretical framework

An exploratory cross-sectional qualitative research study was conducted firstly to understand the perceptions and experiences of sexuality and sexual difficulties among middle-aged Lebanese women aged 40-55 years and examine the way in which they address their sexual difficulties. A secondary aim was to explore the role of nurses and midwives in sexuality-related care.

This qualitative study is connected with a relativist interpretive ontological position which supposes the existence of multiple realities that are socially constructed (Lincoln and Guba, 1985; Denzin and Lincoln, 2000; Green and Thorogood, 2004). The researcher interacts with the participants, gets inside their world to understand their views and experiences that may change from one context to another (Streubert and Carpenter, 2011). Thus, the researcher makes meaning of the subject under investigation. This position aligns with a constructionist epistemology (Gergen and Gergen, 2008).

4.2.1.1. Ontology

Ontology justifies the nature of the reality; what is reality and what are its characteristics (Creswell, 2013). 'Different researchers embrace different realities, as do the individuals being studied and the readers of a qualitative study' (Creswell, 2013, p. 20). Thus, 'there are as many realities as individuals' (Scotland, 2012, p. 11). Guided by an exploratory design, the interviews generated rich data that reflected women's views and experiences of sexuality across their varied social and cultural context and interactions. Thus, women interpreted and made sense of their sexuality as a social reality affected by the world around them. They reflected on the subject using their own words and language.

4.2.1.2. Epistemology

Epistemology accounts for the generation of valid knowledge by the use of appropriate methods (Creswell, 2013). It is concerned with 'how we know what we know' (Crotty, 1998, p. 3); thus, it is about how knowledge is created and what is the meaning attributed to what it is known from the subjective views and experiences of people being studied in their social interactions (Cohen, Manion and Morrison, 2007; Creswell, 2007; 2013). These assumptions are in line with the interpretive and subjective nature of the qualitative paradigm and the constructionist approach adopted in this study where the reality is relative. Data generation is based on semi-structured and focus group interviews where the participants articulate their own thoughts, attitudes and experiences using their own words and languages. As a researcher, I am actively involved in data generation and get inside the

participants' own world (Polit and Beck, 2010; Scotland, 2012). My epistemological position affects the relation with the participants and the meaning making of reality.

4.2.1.3. Social constructionism with a 'twist of pragmatism'

The fundamental foundation of social constructionism is that reality is socially constructed, negotiated and experienced by individuals and groups (Berger and Luckmann, 1966, as cited in Delamater and Hyde, 1998; Gergen and Gergen, 2008). The constructionist's primary concern is that '...what we take to be the world importantly depends on how we approach it, and how we approach it depends on the social relationships of which we are a part' (Gergen, 2009, p. 2). The reality is not discovered by the individual's mind as postulated by the constructivist approach (Young and Collin, 2004). Many researchers use social constructionism and constructivism interchangeably (Charmaz, 2006; Gergen and Gergen, 2008). Yet, no one description of social constructionism is common among writers (Burr, 2006). Its main features are:

- Knowledge is generated by social processes. Meaning-making is the product of constant human relationships, social interactions, events and actions (Guba and Lincoln, 1985; Bryman, 2001; Seale, 2012). The constructionist approach explores the meaning that evolves with the individuals' firsthand experience in a particular situation. Thus, the researcher is concerned with reliability and internal validity rather than generalisability and external validity (Farzanfar, 2005, as cited in Tuli,

2010; Broom and Willis, 2008). As sexuality is socially constructed and influenced by cultural values and norms, a constructionist epistemology was used to account for these influences that are grounded in the sociocultural Lebanese system.

- The understanding of the world is historically and culturally specific (Burr, 2006). It is dynamic and ever changing (Gergen and Gergen, 2008).
- Language is central to the social origin of knowledge and the understanding of the meanings within relationships; in turn these meanings help the creation of comprehensible worlds (Burr, 2006; Gergen and Gergen, 2008). In reflecting on the social construction of illness, Bryan Turner (1995, quoted in Conrad and Barker, 2010, p. 11) notes 'we can no longer regard diseases as natural events in the world which occur outside the language in which they are described. A disease entity is the product of medical discourses'. Acknowledging the importance of language in meaning making, all data were first analysed in Arabic, the native language in Lebanon.
- According to Gergen and Gergen (2008), 'social constructionism is closely allied with a pragmatist conception of knowledge'. That is, truth relies on findings and their implications for cultural life rather than on traditions and naturally-based assumptions. Thus, the consequences of the claim of a truth within a certain

context reflect and sustain the values of people in that context. Social constructionism calls for caution as the assumptions of the world as they appear do not necessarily refer to the reality (Burr, 2006). This implies the possibility of having different 'social constructions' of the world that suppose different kinds of action (Burr, 2006). For instance, the awareness about the rights to express sexuality based on everyone's sexual orientation results into a social action that avoids discrimination and advocates for sexual emancipation. This gives voice to minority and marginalised people for the taken-for-granted scientific realities.

In this study, the combination of pragmatism with constructionism might be atypical as the former has been qualified within the realism ontology (Goldkuhl, 2012; Houghton, Hunter and Meske, 2012) and the later has been criticised for its anti-realist, relativist stance (Hammersley, 1992, cited in Andrews, 2012). The current trend in qualitative research warns against an extremist realist relativist position (Denzin and Lincoln, 2005) and Barbour (2014) advised researchers to keep an open-minded rather than to narrowly adhere to a specific philosophical thought. If the social world is constructed based on research negating the existence of some independent reality, the value of research findings is questionable (Craib, 1997; Hammersley and Atkinson, 2007). However and according to Kuhla (2000), constructionists do not deny the existence of reality; rather they acknowledge that its meaning is socially constructed. For instance, the idea that disease exists as an independent reality (ontological status) is compatible with

constructionism; naming or declaring what constitutes a disease might be socially constructed.

A pragmatist approach to ensure validity of findings is to judge them in relation to what is already known and therefore draw reasonable inferences about meanings (Murphy *et al.*, 1998). According to Hammersley (1992, quoted in Andrews, 2012, p. 43), pragmatism is 'a common sense understanding and consensual notion of what constitutes social knowledge, particularly in judging the validity or truth of such knowledge generated through research findings'. This aligns with qualitative research and the constructionist view where researchers do not claim that their findings are definitive; they present solid arguments to support their validity. This opens a debate that would generate changes based on the plausibility of findings. This flexible constructionist approach is in line with a pragmatist view where findings are judged based on their practicality to generate standards for action and thought (Flick, 2009; Houghton, Hunter and Meskell, 2012). In his article 'Social constructionism and the legacy of James' Pragmatism', Hastings (2002) outlined four main parallels between the two views. These are:

- The utility or convenience is the criterion to evaluate truth, as such, the notion of an absolute or a definitive reality does not exist. Knowledge is provisional; it is produced and determined by social consensus and self reflection;

- A philosophical pluralism that asserts the need to apply methodological plurality to explore the multiple realities. Both views acknowledge the no favouritism of one subject area over another. Considering the inferences as tentative explanations by the pragmatism perspective is supported by constructionist belief that no one theory or language could explain reality;

- The social construction of knowledge is based on subjective approaches that yield objective knowledge, using the language as a social bond while acknowledging the contextual nature of truth;

- The belief in the progression of truth admitting that facts are constructed; they change across time and the survival of truth depends on its utility function. Thus, both views social constructionism and pragmatism belong to broad family paradigms and share more commonalities than differences. As put forward by Lincoln, Lynham and Guba (2011, cited in Jackson *et al.*, 2015), with the development of qualitative research, more combinations of different aspects of theoretical and philosophical approaches will emerge as a plausible methodology of research inquiries. In this way, the present study claims having positively contributed to this assumption.

The principles of social constructionism-pragmatism challenge the positivist paradigm, guide researchers in the understanding of social realities considering the human interchange and discursive conventions and stimulate the curiosity to use innovative methodologies in exploring the ever changing worlds. During the last decades, social constructionism has gained wide use in different disciplines including the field of health and sexuality (Delamater and Hyde, 1998; Appleton and King, 2002; Burr, 2006; Flick, 2009; Conrad and Barker, 2010). In line with social constructionism, the meaning of sexuality is grounded in social interaction, culture language and discourse (Giles, 2006; McElwain, Grimes and McVicker, 2009). Moreover, 'gender ideologies, the cultural set of beliefs and practices about men and women and their relations to each other, construct men's and women's sexualities differently' (Blackwood, 2000, p. 227). From a pragmatist perspective, the meaning attributed to sexuality as a social reality is closely linked to its practicality and usefulness for a specific time and context allowing for continual inquiry and ongoing reflection that constantly stimulates changes (Doane and Varcoe, 2005; Flick, 2009; Houghton, Hunter and Meskill, 2012). This does not necessarily mean that other approaches are not relevant; but this one seems appropriate to answer the research questions of this study. The way sexuality is interpreted and experienced by middle-aged women in Lebanon where knowledge about the subject is next to nothing justifies this research. Thus, framing social constructionism with pragmatism presents the broader interactive and varied influences on sexuality and provides implications for action based on an insider perspective considering the multicultural Lebanese society. In reference to

the pragmatic approach, the socially constructed knowledge generated from this study and its significance will be validated based on its practicality. Otherwise, professionals' interventions will be based on their own judgments.

4.2.1.4. Qualitative research

In reference to Denzin and Lincoln (2005, p. 3), qualitative research is '... an interpretive naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them'. The research approach is informed by the nature of the problem, the researcher's background and view of the world, the audiences and the methodological considerations (Starks and Trinidad, 2007; Jackson, 2013; Astin and Long, 2014; Creswell, 2014). In other words, ontology, epistemology and methods constitute the dimensions of a research paradigm that reflects the world views, perceptions and beliefs of the researcher. These elements determine the nature of the inquiry, the angle from which it will be studied and the framework for analysis and interpretation (Bowling, 2002; Scotland, 2012). Attending to these different elements is essential to produce a good quality of research which provides reliable and valid data (Ritchie and Lewis, 2003; Carter and Little, 2007). Gergen (2014) argued that even for seasoned researchers, the route to excellence is seldom clear and that fixed answers to questions of evaluation do not exist. The most important is to understand a phenomenon from a certain perspective

and not to prove that one methodological approach or the other is right or wrong (Speziale and Carpenter, 2007).

Qualitative health research has contributed to expand knowledge of many clinical situations that are poorly studied and understood and deliver an evidence-based practice that is of high quality and cost effective (Thorne, 2000; Ingham-Broomfield, 2015). Domegan and Flemmin (2007, p. 24) postulated that 'qualitative research aims to discover issues about the problem in hand because very little is known about it. There is uncertainty about the dimensions and characteristics of the problem. It uses soft data and gets rich data'. This approach allows the researcher to understand the unique and complex nature of people receiving or delivering healthcare services and gain insights into their perception, attitude, experience, motivation and behaviour (Clisett, 2008; Britten, 2011; Cleary, Horsfall and Hayter, 2014a). It is therefore recommended to clarify the healthcare needs and practices and barriers to change in the healthcare settings (Pope, Van Royen and Baker, 2002).

As qualitative research explores complex, tacit and sensitive phenomena that are ill defined and unclear (Denzin and Lincoln, 2005; Leedy and Ormrod, 2005), it is best suited to explore sexuality. Thus, women's sexuality was investigated using an exploratory qualitative design underpinned by a constructionist pragmatist position to a) gain insights into women's thoughts and experiences concerning their sexuality and sexual difficulties

within their differing contexts and social interactions; b) understand the facilitators and barriers women identify as related to help-seeking for sexual difficulties; c) give women the opportunity to disclose their sexual concerns and voice their silent needs; and d) provide meanings and explanations for this complex phenomenon within the Lebanese context and in relation to the general literature. The same qualitative design was adopted with a sample of nurses and midwives to understand their views concerning their role in sexuality-related care.

As a health professional believing in the individualised and holistic approach to human beings, a naturalistic paradigm was chosen to capture the different dimension of women's sexuality in their real life and gain deep insights into thoughts, feelings, attitudes and experiences. The direct contact, observation, communication and interaction with the participants deconstructed the complexity inherent to their sexuality which is a taboo topic and optimised the information about the subject through a flexible and emerging process. This could not be provided by a positivist design that is limited to particular concepts and focus of a research inquiry (Polit and Beck, 2010). Data were generated, analysed and interpreted with no a priori well defined conceptualisation of what is to be found in order to produce rich and in-depth information that could be transferable to similar contexts (Lincoln and Guba, 1985; Krauss, 2005).

4.3. Methods

The methods include the study design, settings, sampling, inclusion and exclusion criteria, sample size, access and recruitment, data generation using in-depth semi structured interviews and focus groups, the different topic guides including the use of vignette, the transcultural transliteration of meaning, reflection on interviewing, data transcription and analysis and trustworthiness. The chapter ends with the ethical considerations.

4.3.1. Study design

A cross-sectional exploratory qualitative multiphase design was chosen to capture the participants' views and the researcher's reflective perspectives using individual and focus group interviews. An interpretive inductive process generated a sequential multiphase study whereby the interpretation of findings of one phase informed the inquiry design of the subsequent phase and the refinement of the research questions. The different phases of the study are presented in figure I.

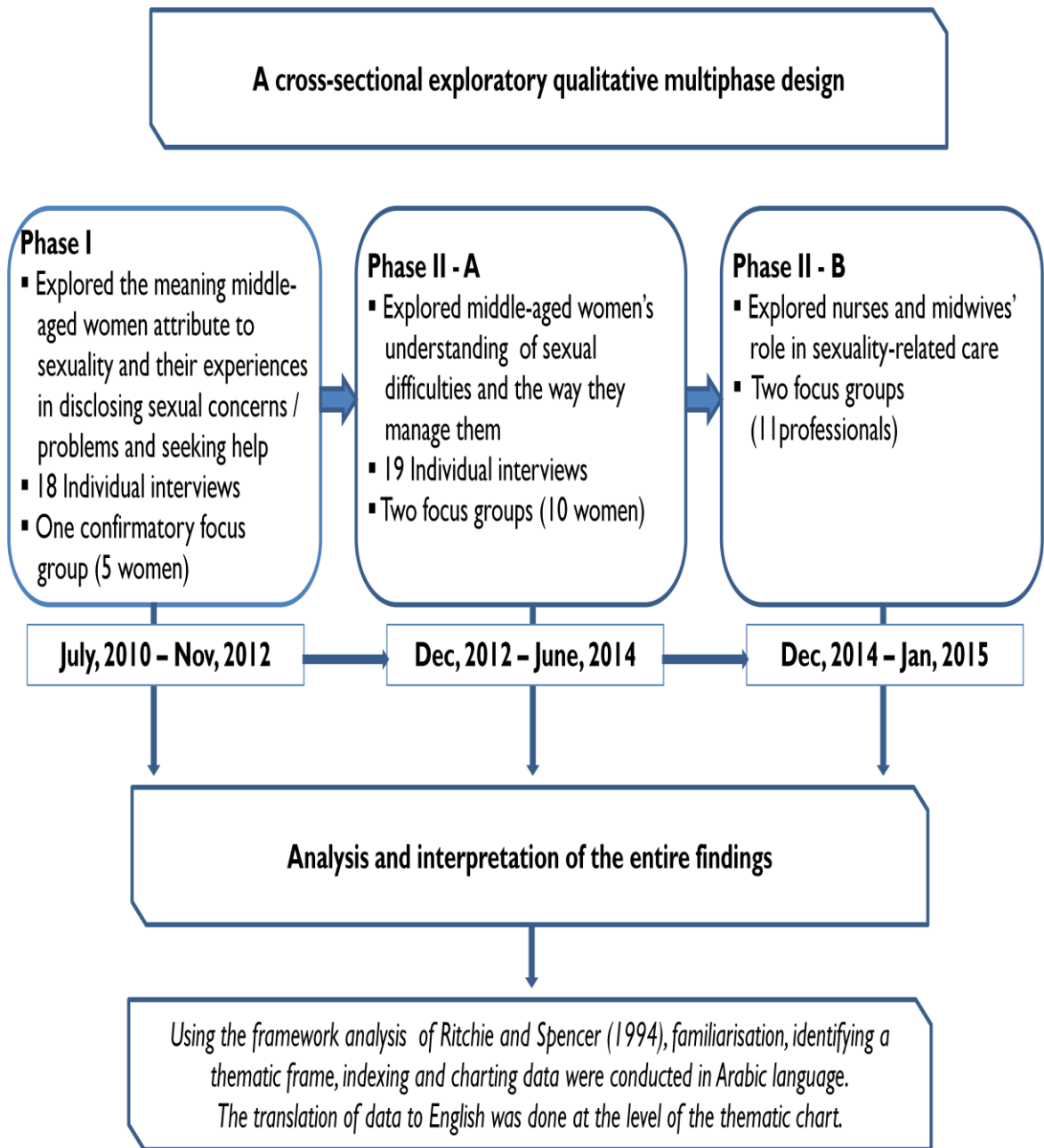


Figure 1. The different phases of the cross-sectional exploratory qualitative design

4.3.2. Study settings

In the first phase of the study, women were recruited from the mammography units of two university hospitals, one private and one public. These hospitals have high enrolment rates and attract clients from diverse socio-demographic and cultural backgrounds. The diversity was furthered by the yearly extensive national Breast Cancer Awareness Campaign which enhanced women's sensitisation and willingness to do the breast cancer screening test. The choice of these settings was intended to optimise the sample heterogeneity and enrich data generation, therefore gaining deep insights into the middle-aged women's thoughts and experiences (Barbour, 2014). These clinical facilities provide safe environments to approach women and invite them to discuss sexual issues, adopting a holistic and non-medicalised stand.

The recruitment process for phase I of the study was difficult and time consuming. In addition, few women reflected on their sexual difficulties. They mainly related them to their husbands' sexual problems. To overcome these challenges and have more variety in women's sexual experiences, the sampling frame was broadened in phase II to include participants chosen from two organisations; two primary healthcare centres which are free of charge and serve a large population coming from different geographic areas and backgrounds; and the Obstetrics/Gynaecology private clinics of one of the above mentioned hospitals. These clinics also receive a variety of clients with different reproductive and sexual health concerns and problems.

In the phase II-B, nurses and midwives were recruited from the same hospital and the two primary healthcare centres as in phase II-A, forming a sample of clinical and community professionals.

4.3.3. Sampling

Qualitative sampling is not a straightforward activity (Guetterman, 2015). It is a critical step of the research process that requires deep reflection to construct a sample in line with the study design and appropriate to answer the research questions (Creswell, 2013; 2014). It does not aim to achieve representativeness and empirical generalisations (Crouch and McKenzie, 2006; Dooks *et al.*, 2012; Maxwell, 2013). The sample is composed of Lebanese women aged 40-55 years. This transitional period in women's life is critical as it is characterised by many physical and psychosocial changes that may affect their sexuality (Myskow, 2002; Deeks, 2003; Nusbaum, Helton and Ray, 2004). The study focused more on providing an understanding of women's experiences during this life period.

A purposeful sample was chosen as it is highly recommended for sexuality research (Wiederman and Whitley, 2002; Gledhill, Abbey and Schweitzer, 2008) and is in line with social constructionism. I chose a variety of participants in their naturalistic environment to draw inferences based on different perspectives and social realities. As provided by Patton (2015, p. 264, quoted in Gentles *et al.*, 2015), 'The logic and power of purposeful

sampling lie in selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry... Studying information rich cases yields insights and in-depth understanding'.

Women were selected purposively by level of education and menopausal status acknowledging their implication in the perception and experience of sexuality (Abdo *et al.*, 2004; Obermeyer *et al.*, 2005; Safarinejad, 2006; Shifren *et al.*, 2008; Valadares *et al.*, 2008). Marital status, religion and occupation were also collected and considered in the research objectives, data analysis and interpretation as they enriched findings.

The levels of education are classified according to the Lebanese systems: University (regardless of the enrolment number of years); secondary (grades 11-12); intermediate (grades 7-10); and elementary (grades 1-6) or less (having not received formal education). The menopausal statuses were defined as follows: a) Premenopause: Regular menses occurred in the past 3 months; b) Perimenopause: Irregular menses occurred in the past 3 to 12 months; c) Postmenopause: menses ceased at least 12 months ago (Smeltzer *et al.*, 2008). Menopause happened spontaneously to all interviewed women.

Snowball sampling was added due to difficulties in identifying eligible women who meet the criteria of a purposeful sample and the sensitivity inherent to sexual disclosure. This

involved seeking information from key informants about details of other 'information-rich cases' in the field' (Suri, 2011, p. 6).

As this sampling method might compromise the heterogeneity (Saumure and Given, 2008), only eight women were recruited by snowball sampling and were selected with a reflective manner to represent different views. Nevertheless, snowball sampling is recommended for sensitive topics such as sexuality (Creswell, 2012; Seale, 2012). It also reduces the bias of a sample chosen from clinical settings where women might be more aware about their general and sexual health and their sexual problems medicalised.

In the phase II-B that explored nurses' and midwives' role in sexuality-related care, nurses and midwives were recruited purposively considering their age, education and work specialty. It was suggested that older nurses who have further education have a positive attitude towards patients' sexual concerns and feel more confident in addressing the topic (Saunamaki, Andersson and Engstrom, 2010). This is also the case for Obstetrics/ gynecology nurses -equivalent to midwives in Lebanon- compared to nurses working in the medical and surgical units (Magnan and Reynolds, 2006).

4.3.3.1. Inclusion and exclusion criteria

Women who participated in the study were middle-aged (40-55 years), Lebanese and spoke Arabic, regardless of their marital status and sexual orientation. Women who had

acute or chronic physical and mental health problems at the time of the interviews were excluded. Their health condition may interfere with the perception and experience of sexuality, adding another layer of complexity to the interpretation of findings (Kralik, 2001; Hautamäki *et al.*, 2007). All women who accepted to be interviewed fitted the criteria of the study and none of them were excluded. In addition, all registered nurses and midwives who had direct patient care were eligible to participate in the study.

4.3.3.2. Sample size

The sample size involves 'judgment and experience in evaluating the quality of the information against uses to which it will be put' (Sandelowski, 1995, p. 183). Fusch and Ness (2015, p. 1413) noted that, 'there is no one-size-fits-all method to reach data saturation; moreover, more is not necessarily better than less and vice versa'. The most crucial is to recruit participants who produce findings that answer the research questions and allow us to draw appropriate conclusions (Koerber and McMichael, 2008; Onwugbuzie and Leech, 2010; Bryman, 2012; Gentles *et al.*, 2015) rather than arbitrarily determine data saturation (Charmaz, 2006). Failing to do so, the content validity is compromised and the quality of the research is questionable (Bowen, 2008). Barbour (2014) argues that to get in-depth understanding of a topic, a small sample size is usually recommended. The review of five hundred and sixty qualitative doctoral theses in Great Britain and Ireland reported sample sizes varying between 1 and 95; the most common being between 20 and 30 (Mason, 2010). A systematic review by Guetterman (2015) of a

corpus of qualitative articles on education and health sciences suggested that the sample should be determined based on its size and appropriateness. The decision involves the researcher's reflexivity to carefully check data saturation.

As such, data saturation was determined based on a pragmatic approach where no more cases were necessary to answer the research questions. This was done having in mind that thick (quantity) and rich (quality) description was provided and that there was no need to have more coding to replicate the study and ensure transferability and credibility of findings (Guest, Bunce and Johnson, 2006; O'Reilly and Parker, 2012; Walker, 2012). Nevertheless, an estimated sample size was a priori identified (54 women and 15 nurses and midwives) in the development of the proposals submitted to the 'Internal Review Board'.

4.3.4. Access and recruitment

In the two phases of the study, the access to the participants required the approval of the administrators of the chosen settings of phase I and II who received an information letter (Appendix two one three) about the study aims, the recruitment and interview procedures, women's voluntary participation and confidentiality of generated data. To preserve women's privacy and only meet eligible ones who accept to take part in the study, it was expected that the first contact with women be conducted by an assigned female staff member of the settings. This was not possible due to logistic limitations and

human resources shortages. So, I handled all the recruitment process by myself. The role of the staff was limited to facilitating the access to women. My direct involvement with the women was beneficial in that I immersed myself in the women's contexts; had many discussions with the supervisors about the recruitment process; and was aware of the factors that prevented some of the eligible ones to participate in the study.

All the potential participants received an information sheet (combined with the informed consent that is detailed in the ethics section about the study and were provided with the necessary instructions about the study and their participation. I encouraged them to ask questions and be sure that they understood all the information in order to make an informed decision about participation on the study. I paid special attention to women with no formal education by spending more time with them to carefully clarify the requirements of their participation.

Recruiting women to participate in the study was a long and difficult process, supporting previous researchers' claims (Howatson-Jones, 2007; Graffy *et al.*, 2009). Approximately two third of those I met refused to participate in the study. The most important challenges were:

- Being engaged in a full time job, it was very challenging to dedicate time to handle the recruitment procedure in all its steps. I had to manage my schedule in a way

that did not compromise my work responsibilities yet allowed me to spend time in the different centres waiting for women's availability. However, I lost many eligible women because I was not continuously available to meet with them.

- Meeting with women in a private place to inform them about the study and their participation was not always possible. I had sometimes to find a comfortable area to discuss with them.

- Initiating the first contact with women to discover later on that they were not eligible to participate in the study because of their age or their non-Lebanese nationality was embarrassing.

- Intruding myself in women's personal life in order to meet the criteria of my purposive sampling was embarrassing.

- Perceiving the constraint around sexual disclosure prevented many women from participating in the study. They expressed their apprehension, uncertainty and timidity concerning the topic. Others did not seem interested or did not perceive a direct benefit in discussing their sexual issues. A notable number was initially willing to participate but declined later on at the time of the interview. Some gave me more than one appointment but in vain. Women's behaviour might have been influenced by their husbands' attitudes. For instance, some participants declared

that they were warned by their husbands not to reveal intimate details of their sexual life.

- Claiming time constraint was a common excuse for many participants although they expressed their willingness to participate in the study. Their refusal was categorical despite the facilities proposed concerning the choice of the time and place of the interview. It was even more difficult to organise the focus group discussions with different participants coming from different places and having divergent schedules.
- Interiorising the taboo around sexuality and ageing, many women around the menopausal age found that it was not worth and even a shame talking about their sexual life.
- Being afraid of stigmatisation or describing themselves as asexual, many single women did not find the interest to engage in a discussion around sexuality.
- Acknowledging the importance of women's sexuality and its implication on their wellbeing, many Obstetrics/Gynaecology physicians expressed their readiness to assist me in the recruitment process and were curious to have details about the topic. Yet, they were not cooperative; they particularly refused to identify any

woman with sexual problems suggesting that any revelation of their case would be stigmatising. They also reported that few women consult for sexual problems. Although the physicians were not supportive, they might have adopted a protective attitude of their patients.

Despite all the challenges, I reached a purposive and varied sample that provided rich data. Nurses and midwives were selected purposively using the list of their profile provided by the nursing administration. The majority showed enthusiasm to participate in the study. Some declined due to their unavailability, timidity to talk about sexual issues and lack of interest in the field.

4.3.5. Data generation

Qualitative data generation relies on naturalistic flexible and open-ended methods. These are congruent with the research questions and philosophical stance to capture the holistic and complex meaning of the participants' social world (Cleary, Horsfall and Hayter, 2014b; Khankeh *et al.*, 2015). In this study, face-to-face semi-structured individual and focus group interviews were used. As the study is exploratory and does not subscribe in any qualitative research approach and as little is known about women's sexuality in Lebanon, the two methods of data generation are well suited to answer the research questions. Both of them aligned with the constructionist-pragmatic paradigm and interpretive methodology of the study by providing deep understanding of the

participants' views, attitudes and behaviours. The two methods complemented one another in a way that potential challenges and limitations of every method separately were surmounted (Lambert and Loiselle, 2008; Gopaldas, 2016). This combination is defined as a triangulation which is a strategy to provide more information and broaden the understanding of the explored subject (Mason, 2006; Loiselle *et al.*, 2007). Yet, some researchers question the value and appropriateness of combining two methods of data generation and the way to articulate them together taking into consideration the theoretical and methodological underpinnings and the aims of the study (Webb and Kevern, 2001; Farmer *et al.*, 2006). More empirical studies are necessary to see the advantage of one method on the other, weigh each data contribution to gain insights into the studied phenomenon and identify the added value of the two methods combined.

Interviewing, people's ability to use the language to tell their stories (Seidman, 2006), is the basic mode of data generation (Noaks and Wincup, 2004; Silverman, 2006; Astin and Long, 2014). Qualitative interviewing gives people the opportunity to discuss their own sexual concerns that are not usually highlighted (Gott and Hinchliff, 2003b). This emancipated approach has been encouraged by feminist researchers to give voice to women in constructing the meaning of their sexuality (Daniluk, 1993; 1998).

In response to a cynicism about the value of the participants' accounts in making sense of the world, Peter Reason (1981, cited in Seidman, 2006, p. 50,) stated that: 'The best

stories are those which stir people's minds, hearts, and souls and by so doing give them new insights into themselves, their problems and their human condition. The challenge is to develop a human science that can more fully serve this aim. The question, then, is not 'Is story telling science?' but 'Can science learn to tell good stories'? The way a researcher perceives the world affects the type of questions and the techniques chosen to answer them (Astin and Long, 2014). 'The skilled, embodied interviewer uses his or her person to communicate with people to create stories' (Nunkoosing, 2005, p. 698) while staying constantly aware of his/her ego (Seidman, 2006).

I conducted all the interviews myself to get insights into the participants' talk and have better control over the different steps of data generation, analysis and interpretation. Richards and Morse (2007) argued that principal researchers are best suited to make data; their interaction with the participants and the collected field notes are important for the interpretive process. Relying on research assistants does not always guarantee high quality data.

A good rapport characterised by tactfulness, interest, respect, confidence, empathy and security is a key element of a successful interview (Richie and Lewis, 2003; Mack *et al.*, 2005). Thus, all the participants were interviewed in a comfortable environment and with respect of ethical considerations. I stressed the importance of their views in constructing their sexuality valuing all that they say. Yet, many participants were careful in choosing

their words. In their article about 'Qualitative interviewing: methodological challenges in Arab settings', Hawamdeh and Raigangar (2014) argued that Middle-Eastern people often present themselves according to social and religious expectations. This presentation influences their capacities to reflect on their thoughts and practice. The authors added that the Middle-Eastern people distinguish between the public and private self; they often tend to give responses that are socially desirable and do not accurately represent their own views. As these people are less open, more cautiously controlled (Okasha, 2003) and largely compliant to the beliefs of their groups (Bohnet *et al.*, 2010), a culturally sensitive approach to interviewing was adopted with the participants of the current study.

Coffee, refreshments and sweets were offered as a way to make the participants feel welcome. Towards the end of every interview and as mentioned previously, I verified women's agreement on the data. I informed them that the results of the study would be disseminated through national and international journals and conferences.

4.3.5.1. Semi-structured, individual face-to-face interviews

Individual interviews are the most commonly used method of qualitative data collection (Sandelowski, 2002, Nunkoosing, 2005). The interview has a conversational style aiming at understanding participants' point of view, attitude, and value concerning a particular subject and the meaning they attribute to it (Kvale and Brinkman, 2009). To avoid overlapping between the different types of qualitative interviews, the term 'semi-

structured interview', as used in this study, is defined as a list of themes and questions that are covered in a flexible manner. It is differentiated from an unstructured or in-depth interview where the interviewee freely talks about an area of interest in a non-directive manner (Suanders, Lewis and Thornhill, 2009). The semi-structured interviews are broad enough to get insights into women's thoughts and experiences and somehow focused to explain the interaction between the explored topic and the way it is contextually shaped. This method has the advantage of being confidential, flexible and responsive to every participant's needs (Kvale and Brinkman, 2009; Silverman, 2011). Applied in the field of sexuality, it offers the opportunity to the participants to reflect on intimate issues and voice their sexual concerns (Azar, Kroll and Bradbury-Jones, 2016). Being face-to-face conducted, data generation is optimised by the direct and indirect communication, clarification of ambiguous questions, probes, support, cues and fieldnotes.

I conducted 37 individual interviews with women; this took place either in my office, the clinical centre or the women's homes. The setting was chosen based upon women's desire. The majority of the interviews were long, lasting around one hour. Dealing with a sensitive topic required my alertness to women's emotional expression and distress. At the opening of the interviews, the majority of the women were perplexed, not knowing what to say. The most difficult question was to express the meaning of their sexuality/sexual life. This required a time of reflective silence. The hesitancy and carefulness were more apparent when they disclosed their sexual difficulties with their

husbands as they feared violating the privacy of their marital life. I provided them with further explanations, rephrased the questions and probed them with ‘tell me more’; ‘what do you mean by...’; ‘give me examples about ...’ The probing method that is inherent to semi-structured interviews (Morrissey and Higgs, 2006) allows for the elaboration of the responses (Babbie, 2009).

With the progress of data generation, I became more confident and flexible. The order of the questions was not systematically respected; the conversation was so spontaneous that it became more interviewee-guided. I gave women the opportunity to extensively talk about their concerns and feelings, pause and then continue if still willing to do so. My concern was to keep control over the interviewing process and to make sure that the main concepts were explored.

4.3.5.2. Focus group interviews

The focus group plays an important role in social science research (Polit and Beck, 2010). It generates qualitative data from a group discussion of six to eight participants about a common topic or concern, usually perceived as a social experience (Then, Rankin and Ali, 2014). This method capitalises on participants’ interaction, spontaneity and exchange to understand the social construction of reality (Richie and Lewis, 2003). It is also widely used in healthcare sciences research (Webb and Kevern, 2001; Mansell *et al.*, 2004; Carlsen and Glenton, 2011) and provides insights into the perceptions and experiences of

health problems, behaviours, services and education (Kitzinger, 1995; Heary and Hennessy, 2002; Twohig and Putnam, 2002; Halcomb *et al.*, 2007; Krueger and Casey, 2009). Focus group discussions are more commonly adopted in the field of sexuality to study a wide range of concerns since they have the benefits of exploring under-researched topics by fostering interaction and making people comfortable to talk (Frith, 2000; Binfa, Robertson and Anna-Berit, 2009; Agunbiade and Ayotunde, 2012). This method explores the participants' subjective and experiential views of sexuality and highlights the sociocultural context that affects these views (Frith, 2000). 'Focus groups can tap previously unrecognised areas of interest because participants often have the opportunity to steer discussions in directions of greatest personal concern' (Frith, 2000, p. 3).

However, in a focus group, the confidentiality is compromised (Bowling, 2002). Some people might be influential and others timid and not getting the opportunity to talk (Heary and Hennessy, 2002; Barbour 2007; Happell, 2007). In addition, the focus group members are difficult to recruit and gather them all together in a specific time; the moderation of the group requires expertise in terms of communication, listening, controlling the discussions and being impartial; and data management and analysis are confusing and tricky (Creswell, 2012). Despite these challenges, this method was invaluable in this study; it stimulated a vivid interaction and conversation among the participants. Women encouraged one another to talk about their sexual life and concerns

overcoming the taboo nature of the subject. Their discussions were so spontaneous that they reflected on very intimate issues like anal sex. They exchanged many convergent and divergent perspectives, building on one another thoughts, arguing their own positions and allowing the emergence of new ideas and consensual viewpoints. The focus group discussions generated rich data that contributed to more in-depth understanding of women's sexuality.

At the start of every focus group, the participants [women, nurses and midwives] were introduced to each other; we conversed together and got familiarised with one another, to fostering group discussion and interaction. The discussion was rapidly stimulated by the synergy created among the participants. All were excited to reflect on their ideas, debate their differing views, exchange their concerns and support each other. Quoting Traynor (2015, p. 48), 'Focus group research can be stimulating, because of the energy generated within a group and because of the challenges of working with data from a range of perspectives'. Carefully watching the conversation, my interference was maintained to a minimum and the participants led the discussion. Sometimes, I had to put order in the group as the participants were overlapping one another owing to their eagerness to share their thoughts. I also had to temper the dominance of some of them to give the chance to the less talkative to give their opinion. After having saturated the discussion on one item, I was wrapping up the main ideas and then moving to a new question.

The different focus group discussions lasted two to three hours and a half. According to some authors, this duration should not exceed two hours (Plummer-D'Amato, 2008; Doody, Slevin and Taggart, 2013). It was difficult to set strict rules for the length of the focus groups in view of the participants' enthusiasm and fervent need to discuss the subject.

4.3.5.3. Topic guide of the individual interviews with women: Phase I

In phase I, the topic guide consisted of a vignette with a series of open-ended questions and a range of probes in addition to questions about women's socio-demographic characteristics as well as health and menopausal statuses (Appendix four). The vignette was applied to overcome the sensitivity around sexual disclosure and the difficulty of exploring taboo topics. The participants were asked to comment on a situation that portrays a woman's attitude and experience concerning the disclosure of their sexual concerns. Other questions elicited the meaning women attribute to sexuality, sexual disclosure, sexual changes around the menopausal period; the way they manage their sexual difficulties and the facilitators and barriers to help-seeking.

The vignette technique is used in qualitative research to elicit perceptions, knowledge, opinions, beliefs and attitudes from participants' responses to stories in written or pictorial form (Barter and Renold, 1999; Paddam, Barnes and Langdon, 2010). These stories are hypothetical and serve to prompt the participants to respond to a particular

situation (Hughes and Huby, 2002; Spalding and Phillips, 2007). It is made clear that the focus is on the character of the vignette rather than on the participants, releasing them from the burden and embarrassment of talking about their personal issues (Wilks, 2004; Bradbury-Jones, Taylor and Herber, 2012). Yet, the vignettes are authentic and conceivable in that they encourage the participants to talk about themselves (Renold, 2002). This technique encourages openness and avoids embarrassment (Richie and Lewis, 2003; Wilks, 2004) which potentially enriches data generation. Thus, the vignette spontaneously prompts people to digress of the hypothetical story and draw on their own thoughts and experiences (Richman and Mercer, 2002).

Vignettes have been widely applied in different research disciplines and the social sciences research, particularly when the topic is sensitive. This technique was successfully used in exploring sexuality and ageing (Agunbiade and Ayotunde, 2012) and other 'Complex Public Health Issue' (Jackson *et al.*, 2015). It was well-received, effective and generated in depth information. However, the vignettes have been criticised for their hypothetical nature (Finch, 1987; Barter and Renold, 2000; Paddam, Barnes and Langdon, 2010), orienting the participants towards a particular side (Gesch-Karamanlidis, 2015). Finch (1987, p. 113) suggests that 'asking about what a third party ought to do in a given situation is not the same thing as asking respondents what they themselves think they ought to do'.

Being aware that the more the vignette is hypothetical, the less the responses are authentic (Hughes and Huby, 2004; Bunting, Lazenbatt and Wallace, 2010), the vignette of this study was conceived with brevity, simplicity, authenticity, appropriate language and in alignment with the constructionist epistemology of the study and participants' values (Finch, 1987; Grønhøj and Bech-Larsen, 2010; Bradbury-Jones, Taylor and Herber, 2012). The vignette was developed with the assistance of the supervisors; both of whom are experienced in the use of this method. Women were rapidly introduced into the context of the study and reflected on their insights. For instance, when I asked *Fadwa* about her opinion concerning the reluctance of the woman of the vignette to talk about her sexual life, her answer was: *'In our upbringing, we were not talking about sex. This woman (of the vignette) is 49 years old. In the past and I passed by that, we were not talking about sex in the family'*. Other quotes that illustrate women's reflection on their own experience were: *'I will talk about my case'*; *'relying on my experience'*; *'I can talk about myself'*; *'let me recount my story'* and so on. The use of the vignette also helped me overcome my hesitancy in discussing a sensitive topic that may violate women's privacy as sexual discourse is not common in daily clinical practice.

4.3.5.4. *Topic guide of the confirmatory focus group interview with women: Phase I*

This topic guide (*Appendix five*) was informed by the key findings of the individual interviews of phase I. Open-ended questions were conceived focusing on the participants' perception of sexual life and how it was affected by menopausal changes; the way they

perceive their own and husbands' sexuality; the silent sexual discourse; the stigma around their husbands' sexual problems; the perception of female sexual problems; the facilitators and barriers to help-seeking and the role of nurses and midwives in sexuality-related care.

4.3.5.5. Topic guide of the individual and focus group interviews with women: Phase II-A

In this phase, another topic guide (Appendix six) was developed to answer the research questions of this phase. It was composed of open-ended questions that elicited women's understanding of a good sexual life, their perception and experience of sexual difficulties and the way they manage them, their expectations of the health professionals' role in sexuality-related care including nurses and midwives'.

4.3.5.6. Topic guide of the focus group interviews with nurses and midwives: Phase II-B

In this phase, a fourth topic guide (Appendix seven) was designed to lead two focus group discussions with 11 nurses and midwives to point out their perceived role in sexuality-related care, the factors that may shape this role and the suggestions to be more efficient in this field.

4.3.5.7. Pilot-testing the topic guides

In the first phase of the study, the topic guide was pilot-tested with four women of different backgrounds. Women were asked to comment on the meaning and

understanding of the questions; I discussed with them undesirable words or phrases and agreed on the amendment alternatives. Being a novice qualitative researcher, some questions were narrowly focused and leading in that women's answers were either passive or irritating. For instance, in response to the following question, 'Is it true that middle-aged women do not think about their sexual life?' One woman said: *'you are absolutely right; why I should think about these issues. The woman of the vignette is right'*. However, another one told me *'Ouf! Why you are saying that? I am still young. Women of my age have not yet gotten married. I am sure that the woman of the vignette has marital problems that affect her sexual life'*. Another question was: 'What makes it difficult for women to express their thoughts and feelings about sexuality?' One woman commented on the question by saying: *'It might be difficult and it might be something normal. This depends on every woman; you cannot generalise'*.

The questions were refined progressively from one interview to another to become more comprehensive and objective, ensuring clarity, consistency and authenticity of the content. The vignette was shortened and simplified although questions about the meaning of sexuality for women were added to situate help-seeking in a broad context. Another question was also added about the health professionals' role in sexuality-related care. The incorporation of these questions was decided upon the first data analysis. The same pilot-testing procedure was undertaken in phase II-A with two women whereby some questions were reworded without introducing major changes. The topic guide of the

confirmatory focus group and the one used with nurses and midwives were not piloted as they were informed by the participants' responses during the individual interviews.

4.3.6. Reflection on interviewing

Interviewing was a demanding activity that took place at different stages of the study. Yet, it was an enriching experience whether conducted individually or within the focus groups. Every interview was a step forward in my study journey. The interaction with women, delving into their narratives was engaging in that it triggered my curiosity and enthusiasm to know more about a topic that is still neglected. I liked the idea of coming to increasing my understanding of how women think and behave concerning their sexuality and the contradictions that they live. I also recognised the quality of qualitative interviewing; the interaction with the participants, probing to get deeper information gave me satisfaction concerning the understanding of the topic. To a certain degree, my involvement in qualitative interviewing contributed to meaning making of women's talk and generated new knowledge within a particular social context as also suggested by other authors (Roulston, DeMarrais and Lewis, 2003). Yet, I stayed vigilant about my subjectivity. As noted by Gesch-Karamanlidis (2015, p. 2) 'However, we are careful not to over-insert ourselves into the space we've created for our participants, in a way that would negatively impact our ability to hear their voices'. Qualitative interviewing being flexible, I sometimes felt that I pushed the boundaries to know more about women's stories. Afterwards, I

questioned my manner and discussed it with my supervisors. I learned to be more prudent weighing women's willingness to talk with the pertinence of what they disclosed.

Returning to women's home was time consuming and hard to locate the residence area. I had to deal with many interruptions, intrusions of family members, noises around the house and the women's need to draw the interview to a close to attend to domestic chores. All these factors altered the concentration on the discussed items and the smooth and coherent flow of the interview. To minimise this bias that may affect the quality of data generation and keep women focused, I had to repeat the questions and make sure that they were sufficiently answered. Despite all, interviewing the participants in their own environment renders them more comfortable, positively influencing their relationship with the interviewer (Olliffe and Mroz, 2005).

In addition, some interviews were loaded with women's difficult stories. I had to control myself to avoid losing my objectivity and become affected by their suffering (Polit and Beck, 2003). Of course, my position as a researcher did not allow me to go beyond this framework. Yet, I referred needy women to a source of help. The experiences I had with women broadened my mind as a qualitative researcher; I learned to be more open and flexible and less judgmental. I gained maturity in listening, understanding and reflecting back objectively, critically and positively. My connection and interaction with the women made me more aware of my feminist views and instilled in me the desire and

determination to support them and advocate for their sexual rights. Interacting with the participants could not guarantee my absolute impartiality. For instance, the pseudonyms were not spontaneously chosen. I was careful to match them with the participants' characteristics. Nevertheless, debriefing with the supervisors and other researchers and people was a continuous exercise that helped me maintain my objectivity.

Another point that confused me was my position as a single woman who hypothetically - considering the culture on sex outside marriage in Lebanon- is expected to be sexually naive but is interviewing on issues about sexuality. From one side, it was difficult for me to reveal my marital status as women would, presumably, feel more comfortable with a married woman who would supposedly be better equipped to understand their concerns. In consultation with my supervisors, I did not allude to my marital status during the interviews but I did so afterward if asked. Miller (1997) suggests that the researcher shares with the interviewees some personal information that is important to facilitate the interview. Arab participants tend to be more at ease with an interviewer who has similar characteristics (Bohnet *et al.*, 2010). Middle-Eastern people are more at ease with a middle-aged married woman with children, as these characteristics are the indicators of maturity and success (Hawamdeh and Raigangar, 2014). The interviewer's lack of empathy and cultural sensitivity inhibit the interviewees particularly when reflecting on a sensitive topic (McIntosh and Morse, 2015; Nguyen, 2015). Being aware of the researcher's

influence on the participants, I approached women in an individualised manner, respecting their divergent socioeconomic and cultural backgrounds.

4.3.7. Cultural transliteration of meaning

The present study was conducted in Lebanon with Lebanese participants whose native language is Arabic; it was written in English. It was mainly supported by a western literature that reflected the views of women whose culture is different in many ways from the Middle Eastern and particularly Lebanese cultures. I had to be cautioned about the complexity inherent in the transfer of the cultural meaning conveyed by the language and the implications this might have on the accuracy of findings. Unlike the positivist designs where the translation is rather technical, the process is a big concern in cross-language studies as the interpretation and understanding of particular concepts might be different from one language to another (Temple and Young, 2004; Xian, 2008; Al-Amer *et al.*, 2015). Due consideration was given to the translation process to avoid lexical errors and contextual biases.

A very brief idea about the Arab language would help understand the challenges that relate to the translation process. The colloquial Arabic dialect used in daily conversation is different from the written, official language. The Arabic language is characterised by its richness and diversity and is imbued with metaphors as it was immersed in the poetic era for thousands of years (Gu, 2014, cited in Al-Amer *et al.*, 2016). The verb is often

placed at the beginning of the sentence; the adjectives follow the nouns and a mistake in one word might alter the meaning of a whole sentence; the present perfect tense does not exist and is rather depicted from the context (Wright and Caspari, 2011). The language has two genders, feminine and masculine, that are applied to all the content of the sentence.

I only translated the quotes; this was another challenge particularly when I had to convey the meaning of an anecdote or metaphor that is culturally driven (Lakoff and Johnson, 1980). Thus, conveying the same meaning of metaphors between different languages that denote divergent cultures is very tough particularly that word by word translation is not accurate (Lakoff and Johnson, 1980; Simawe, 2001). For instance, *'the one that was uniting us died'*, was said by one participant to allude to her husband's sexual impotence. The use of euphemisms or another language as a substitute for intimidating and unpleasant words in Arabic language was common. Example *'We lived in an environment where there was no this (sex)'; 'My husband's thing (penis)'; 'There are issues, sometimes the sexual problem means that the woman does not reach a particular thing (orgasm) when she does sex. I mean she wants this thing to happen (get her orgasm) but she does not reach it'. Sex, penis, vagina, penetration...* are words often used in English or French language.

The participants' quotes in Arabic figure in the analysis chapters in parallel with the English versions in the interest of transparency and to benefit bilingual people and reduce

what might have been lost in translation. These quotes that served to strengthen the researcher's interpretations and claims (Creswell, 2014) imposed additional burdens. Although textual translation is the rule of thumb in qualitative research, it does not always transmit the intent of the participants. Thus, sometimes I had to introduce a few changes or add words between brackets to convey the participants' thoughts. This required a lot of reflection to transfer clear and accurate meaning without altering the literal sentence. For instance, one participant said *'there is a big difference if she is a girl... it is very important to be a woman to talk about her sexual life...'* The participant meant that a non-married woman does not have the right to talk about sex as this is forbidden outside marriage. However, the expressions 'girl' and 'to be a woman' could be understood by a non-Arabic reader as related to social gender. In the Arabic language and in this context, 'girl' means 'non-married' and 'woman' means 'married'. I had to make this adjustment to accurately convey the participant's responses.

Additionally, in Lebanon, the term sexuality '*jinsania*' is not common and is not used in the colloquial language. Very few people are aware of this terminology. Sexual life is usually used to refer to sexuality and sex is used to strictly refer to sexual act/intercourse. The differentiation between the two concepts and the meaning attributed to each of them are depicted from the context. In phase II-A that related to women interviews, the construct 'sexual wellbeing' was used to replace 'sexual health' which was narrowly interpreted by

women focusing on a biomedical view. Since a literal translation of 'sexual wellbeing' into Arabic was difficult to achieve, I replaced it by 'good sexual life'.

At the different stages of the study, I was involved in translation and back-translation processes following the WHO (2010) guidelines. The interview guides, initially developed in English to discuss with the supervisors, were translated into Arabic. I did forward and back-translation and then pre-testing. At the first step, a qualitative nursing researcher with a PhD translated the original document to Arabic using simple and clear language, emphasising the conceptual meaning of the document content. In a second step, an MPH holder did the back translation. Then, two bilingual persons, and a teacher of English language and I compared the original and translated versions to ensure an authenticity of the meaning. Few gaps were identified and rectified. Then, another PhD qualitative nurse researcher blind to the original version translated the English document back to Arabic. This step did not necessitate any further amendments and the interview guide was ready for pretesting. The same translation process was conducted with the consent forms.

The same procedures were iterated with the other interview guides but the persons changed based on their availability. My familiarity with the topic made this exercise less demanding. I also went through similar translation and back translation processes with two interviews of the first and second phase of the study, assisted by two qualitative

researchers with a PhD. Their input was important for the translation process and for peer debriefing as they share the same culture.

I did not refer to a translator although he/she might have been useful (Al-Amer *et al.*, 2015). Such a person does not usually have the general background of the topic and might introduce bias by bringing his/her own values into the data (Temple, 2002). In addition, the translation process helped me immerse myself in the data and get more insight into the participants' excerpts.

4.3.8. Data transcription

Data transcription is a means of converting verbal audiotape data to a written document. This is an essential part of data analysis to ensure rigour and be true in the conceptualisation of the participants' reality (Seale and Silverman, 1997; MacLean, Meyer and Estable, 2004; Sutton and Austin, 2015). Every interview was immediately transcribed verbatim along with all the fieldnotes as well as both verbal and non-verbal cues like silence, pauses, hesitations, worries and laughs. Reflections, impressions and preliminary interpretations were added as they were still fresh in my mind. This was helpful to situate myself in the real context of the interview (Warr, 2004). The transcripts ranged from 4 to 75 pages, generating massive volumes of data. I transcribed the majority of the interviews. With the progress of data collection and analysis and due to the burden of work load of the study, I was assisted by a BS student in the transcription of some

interviews. Every transcript was read at return, listening alongside to the audiotape to check for accuracy, make adjustments and add notes. This mitigated the possibility of having errors that according to Poland (1995) may reach as many as 60% of the transcription done by a professional. The transcription was meticulous and the corrections were negligible. All data were verbatim transcribed and analysed in Arabic.

4.3.9. Data analysis

Data analysis ‘...involves taking constructions gathered from the context and reconstructing them into meaningful wholes’ (Lincoln and Guba, 1985, p. 333), implying creativity and critical thinking to get a conceptual framework robustly supported by findings (Bazeley, 2009; Kelly, 2009). Data analysis supported by memoing and fieldnotes, informed data gathering in an iterative, analytical and inductive process of comparing and contrasting propositions and developing patterns. Early analysis served to adjust the topic guide, revise the research questions and clarify the research topic (van den Hoonaard and van den Hoonaard, 2008; Saunders, Lewis and Thornhill, 2009; Creswell, 2012). Thus, the emergence of the initial themes served to build on data collection and analysis in a way that one interview informed the subsequent (Bryman, 2004; Sutton and Austin, 2015). This process generated empirical interrelated themes that formed a framework explaining the what, why and how of women’s construction of sexuality. According to Strauss and Corbin (2008), this framework could orient future research and be tested elsewhere.

Data analysis was informed by the Framework Analysis: A Qualitative Methodology for Applied Policy Research, described by Ritchie and Spencer (1994). The framework was initially developed by 'Social and Community Planning Research'; it was expanded and refined over time (Ritchie and Spencer, 1994). The framework analysis is well suited in qualitative research to answer research questions that inform the development of strategies to improve practice. It provides a five-stage process that is clearly structured moving back and forth from raw descriptive data to a higher level of abstraction rendering the complex nature of qualitative data easy to manage and transform to meaningful outputs. This hierarchical analytical approach that served to construct data in a meaningful conceptual frame required first, to get a deep understanding of the data to reproduce the participants' thoughts accurately; second, to situate data within the general understanding and context of the topic and third, to interpret data within a broader theoretical view. Data were managed deductively from the aims and objectives of the study even though grounded and inductive (Gale *et al.*, 2013). The framework analysis in its five-stage process is presented in figure II.

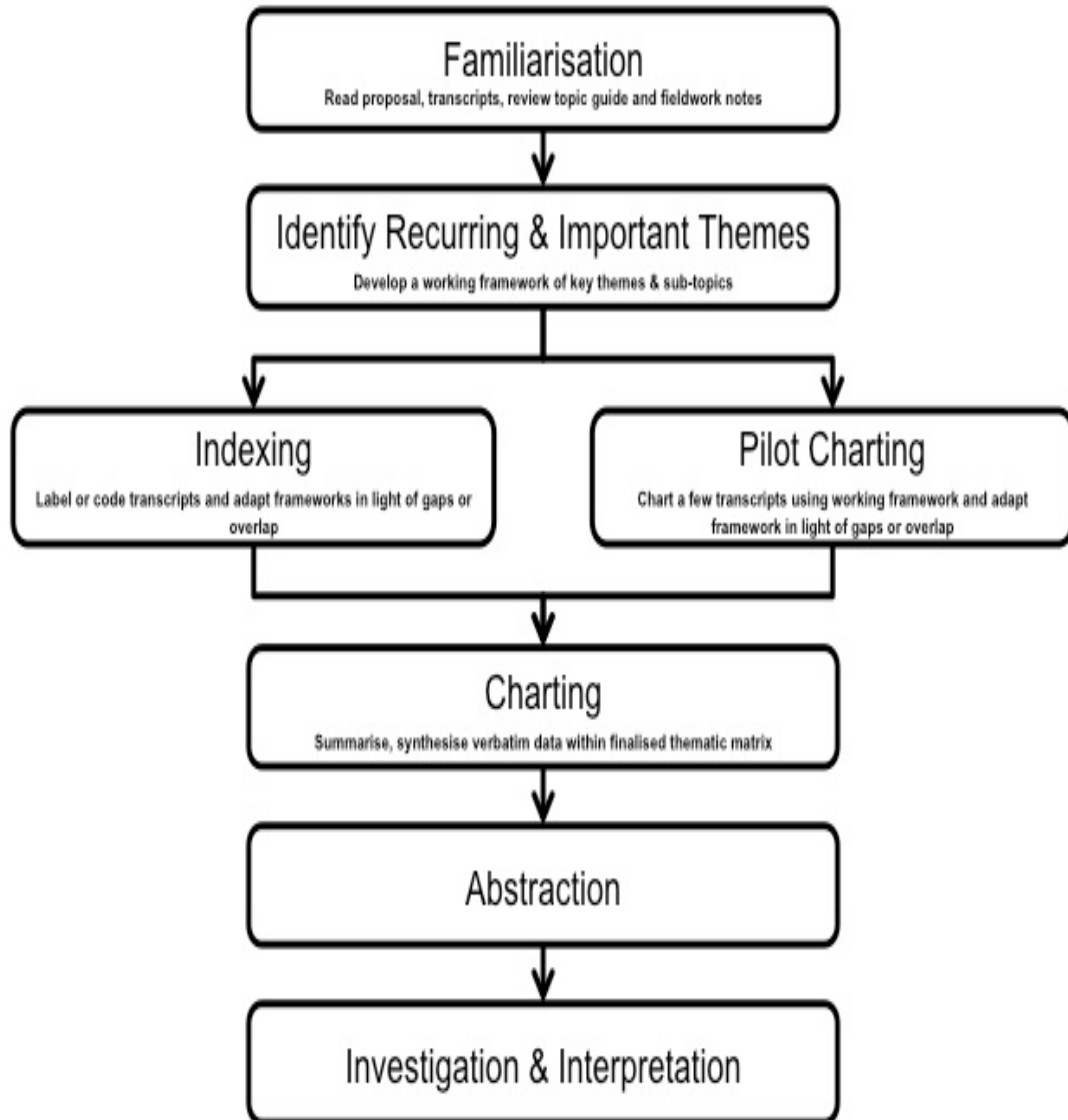


Figure II. The different steps of the framework analysis of Richie and Spencer (1994)

Data were manually managed as I felt myself more comfortable and in control of the content by doing hand analysis. The use of software programme for qualitative analysis would have been helpful in organising, visualising, storing and easily locating data (Creswell, 2013) as I had huge data to manage. Yet, this method might diminish the researcher's creativity and engender technical problems especially for unskilled researchers (van den Hoonaard and van den Hoonaard, 2008; Creswell, 2012) as I did not develop my skills in the use of software. Based, on my supervisors' advice and the literature (van den Hoonaard and van den Hoonaard, 2008), there is no evidence that the analysis would be any better by the use of software.

The analysis of data generated from the individual interviews and focus group discussions with women was conducted separately using the same process and then combined without privileging one method over another (Duggleby, 2005; Lambert and Loiselle, 2008). This was done in due consideration of the methodological underpinnings of the study to avoid any potential compromise of the rigour (Barbour, 1998; Tobin and Begley, 2004). Data collected from the two focus group interviews with nurses and midwives were analysed separately using also the framework analysis of Ritchie and Spencer (1994).

4.3.9.1. Familiarisation

During the first stage, engaging in critical listening of the tapes and thorough reading through the transcripts and fieldnotes were necessary recurrent activities to immerse

myself in the context of the data and be closer to the women's thoughts. This allowed me to get a sense of the whole before segregating the data into segments of different meanings (Ritchie and Spencer, 1994; Creswell, 2013). Memos of ideas and key concepts were written on the margins, looking over the fieldnotes and reflections. With this initial step, I gained awareness about the recurrent ideas and key themes paving the way for coding and indexing.

4.3.9.2. Identifying a thematic frame

The thematic framework characterised by the classification and structure of data is central to the framework analysis of Ritchie and Spencer (1994) to data analysis. It was drawn up of a series of concepts that emerged from the thorough and critical reading and re-reading of the first interviews. It was shared and discussed with the supervisors who separately analysed two interviews that were translated into English. Separate analyses were compared and discussed in face-to-face meetings. Few discrepancies, mostly related to cultural nuances, were identified. In this way, the supervisors got familiarised with the data and I gained confidence in conducting the analysis of the subsequent transcripts. This stage was undertaken with a flexible mind, allowing data to emerge from findings rather than to fit into apriori conceptions (Srivastava and Thomson, 2009; Creswell, 2013). Additionally and as suggested by Ritchie and Spencer (1994), the initial thematic framework, formed of a very broad set of themes and subthemes, was tentative and further refined with the progress of analysis. It served as an index to filter and classify

data and was adapted with every new transcript to include new concepts. This analytical step was very critical; it required a lot of reflection and logical thought to make relevant judgment on the meaning of data and find the interconnectedness between ideas across participants. The thematic frame of phase I, II-A and II-B are displayed in the Appendices eight, nine and ten with the different themes and subthemes coded by numbers. The themes and subthemes were loosely defined to have a consistent categorisation of data and avoid confusion.

4.3.9.3. Indexing

In the indexing activity, the thematic framework was applied to all the transcripts that were displayed in individual tables. Using one column at the margin, the coded themes and subthemes were introduced alongside textual data as appropriate. Key words, sentences and excerpts were marked by different colours, highlighted by different colours or underlined to facilitate their classification in the next step of analysis. Another column was inserted to add particular notes and important ideas. Overlapping passages in more than one index [theme or subtheme] required a deep immersion in the data and a critical consideration to label them under the most appropriate category. An example of overlapping passages is shown in Appendix eleven.

4.3.9.4. *Charting*

As all data were indexed, passages across all participants were cut and pasted to a chart which presented the participants in rows and the indices in columns. This allowed for organising, classifying, comparing and contrasting the data. The cut and pasted passages were largely extracted and referenced the corresponding participants and page numbers to avoid losing their contextual meaning and placement. An example of the thematic chart is displayed in Appendix twelve. Data were then sorted and assembled in a set of individual files for every index category. Charting was an iterative process that required an inclusive view of data to decide on emerging and collapsing themes and subthemes. At this stage, data were shifted as raw material to keep the essence of the participants' talk and further make sure of the categorisation of the quotes. All the data moved to the thematic chart appeared in the native Arabic language. The translation was done at the level of the thematic chart. An example of data translation at the level of the thematic chart appears in appendix thirteen.

The selected data were summarised and synthesised in English and supported by relevant quotes that were translated textually. Some authors recommended doing the analysis in the language of the interviewees (Twinn, 1998; Al-Amer *et al.*, 2015) to minimise the misrepresentation of their views (Irvine *et al.*, 2007). Making sense of women's narratives in their native language helped me better understand the meaning inherent to the culture. It also reduced the burden of translation of the whole content of every transcript.

4.3.9.5. *Mapping and interpretation*

In this step, data were further sifted and the themes and subthemes refined to be congruent with the participants' thoughts. Guided by the Framework Analysis of Ritchie and Spencer (1994), this step implied 1) the identification of the key elements of the different themes; 2) the refinement of the categories supported by descriptive data and 3) the reorganisation of the categories within a higher level of data abstraction. The different categories were carefully re-examined and the key data highlighted and compared in relation to the different categories, within individual transcripts and across the participants. Supporting some authors' views (Li and Seale, 2007; Gale *et al.*, 2013), this step was challenging to include the most relevant and succinct information without being lost in the details. With the evolving process, a schematic diagram was generated with a higher level of abstraction linking the themes and subthemes in a structured way that is reflective of women's social realities. In reference to Ritchie and Spencer (1994), this theoretical frame guided data explanation and interpretation and the development of strategies. The conceptual framework is diagrammatically depicted in figure III in the findings chapter IV.

The analysis process of data generated from the focus group interviews with nurses and midwives yielded five themes that are presented in the analysis chapter V. These themes gave an idea about the role of nurses and midwives in sexuality-related care. Examples of

the analysis process of data generated with women and nurses and midwives are displayed in the appendices fourteen and fifteen.

4.3.10. Trustworthiness

Trustworthiness is the degree to which findings are believable due to their subjectivity and lack of generalisability (Richards, 2009). Admitting that qualitative research studies the world from a particular angle, it is as rigorous as quantitative research (Cope, 2014). Credibility, dependability, confirmability and transferability are the commonly recommended criteria initially proposed by Lincoln and Guba (1985) but still widely used to ensure the quality of qualitative research (Silverman, 2011; Barbour, 2014). Trustworthiness refers to rigour at the level of the process and outcome of the study, showing transparency in the different steps of the methodology and interpretation (Lincoln and Guba, 1985; Dixon-Woods *et al.*, 2004). Several strategies have been commonly adopted for this purpose like member check, triangulation, external audit etc., to reach this end (Creswell, 2012). However, considering ‘one size fits all’ qualitative research is meaningless (Barbour, 2001, p. 1) particularly when adopting a constructionist approach that supports multiple social realities. Yet, some strategies were adopted in this study to promote rigour.

4.3.10.1. *Credibility*

Credibility or internal validity refers to the accuracy of findings; their congruence with the reality of the participants' experiences and meanings they attribute to a phenomenon (Polit and Beck, 2012; Creswell, 2014). Validity of findings was checked by ensuring transparency for all the decisions made through reflexivity. This implied a 'continuous process of critical scrutiny and interpretation' including relational and personal aspects of conducting, interpreting and representing research (Guillemin and Gillam, 2004, p. 275). Yet, this concept is dubious and should be carefully employed to meet its purpose (Darawsheh, 2014). I engaged myself in reflexive practices, aware of the interferences of my beliefs and values and the socio-cultural perspectives in the research process (Harrison, MacGibbon and Morton, 2001; Hoover and Morrow, 2015). This was facilitated by the use of an audit trail that helped me maintain control over the long and complex study progress. It allowed me to keep methodological and analytic documentation, follow the thought processes, track all the decisions made and show transparency and rigour (Bradbury-Jones, 2007; Ward *et al.*, 2013). As part of the PhD study, my supervisors maintained a constant follow-up on the different steps of the study and all major decisions were consensually made. This teamwork further enhanced rigour (Dixon-Woods, 2011). As the supervisors are European and their contextual background is different from mine and the participants', they raised many inquiries that stimulated my reflexivity and critical mind to be more explicit, clarify meanings and unfold hidden issues, thus, adding to the in-depth understanding of findings. I presented the study at different

points of its elaboration in seminars, forums, and local and international conferences. I often discussed the research process and findings with peer Lebanese and Middle-Eastern Arab researchers, colleagues and people from different backgrounds. These activities greatly contributed to challenging my assumptions, monitoring my position and judgment and better contextualising findings. A confirmatory focus group was an additional strategy adopted in the first phase of the study that supported findings of the individual interviews and generated new insights.

4.3.10.2. Transferability

Qualitative research explores a particular phenomenon in a certain population; thus the aim is not to generalise although this becomes more common with the meta-synthesis of findings (Leung, 2015). Transferability is ensured by providing enough information about the context of the study and characteristics of the sample to determine the fit of findings in similar settings (Shenton, 2004). A thick description of data was provided through individual and focus group interviews with different purposeful samples chosen from different settings. Women extensively reflected on their thoughts and experiences generating lengthy transcripts. A contextual and in-depth understanding of women's sexuality is congruent with the constructionist paradigm. It also allows making decisions about transferability (Hoover and Morrow, 2015). Creating a good rapport with women also contributed to 'full and rich descriptions necessary for worthwhile findings' (Polkinghorne, 2005, p. 142).

4.3.10.3. Dependability

Also termed reliability, dependability is about the replicability of the research study, although this definition is in conflict with the intuitive nature of the research paradigm (Leung, 2015). Hence, dependability is concerned with the consistency of the study (Carcary, 2009; Grosseohme, 2014). According to Leung (2015), 'A margin of variability for results is tolerated in qualitative research provided the methodology and epistemological logistics consistently yield data that are ontologically similar but may differ in richness and ambience within similar dimensions' (p. 326). A meticulous audit trail of all the details of data collection and analysis and all the supervisory minutes of the meetings were documented and served as reference to support my decisions. I also constantly listened to the audio-record and compared between the different themes and subthemes to make sure of the contextual interpretation of findings. This process was facilitated by classifying all the extracted quotes of each transcript per participants and all the themes and subthemes across participants. As mentioned earlier, two transcripts were analysed and discussed separately by the supervisors and myself to ensure accuracy. Moreover, all the selected accounts that were coded and extracted were translated into English, printed out and cut into different pieces, one quote per piece without any label. They were sorted by the supervisors together and categorised under different themes and subthemes. A theoretical model was drawn schematising the storyline of findings. Then, a comparison was made between the initial coding and the one developed by the supervisors until a consensus was reached. This procedure was reassuring as it allowed

further examination of the data. It also showed that the different analysis processes undertaken by the supervisors and myself produced the same core findings. This exercise was done in the first and second phase of the study.

4.3.10.4. Confirmability

Confirmability is equivalent to the objectivity of the study; it is ensured by providing evidence that supports participants' talk rather than the researcher's views (Shenton, 2004; Polit and Beck, 2012). Strategies used to enhance the confirmability of the study were auditing to ensure consistency and peer debriefing to have an external evaluation of findings, tempering my own subjectivity. Data presentation was extensively supported by quotes that were translated in English paralleled with the original version in Arabic. The translation back-translation was meticulously conducted to maintain as authentically and accurately as possible the participants' own ideas.

4.3.11. Ethical considerations

Qualitative researchers usually explore sensitive topics and delve into very personal issues that evoke ethical considerations. The language of silence about sexuality, coupled with the privacy of the marital relationship prompted a set of ethical questions about women's vulnerability and sometimes need for protection in andocentric societies.

At every step of the research process, from the conception of the study to the dissemination of findings, the researcher has to carefully attend to ethical considerations (Flick, 2009; Creswell, 2014). Ethical approval for the present study was first obtained from the Research Committee/ Institutional Review Board at the University of Balamand and Saint Georges Hospital University Medical Centre. Another one was obtained from Rafik Hariri University Medical Centre as I recruited women from their setting in the first phase of the study. The ethical approval forms were endorsed by the University Research Ethics Committee (UREC) at the University of Dundee. The ethical approval is a confirmation of the scientific merit of the study and the respect of the ethical considerations (Polit and Beck, 2010; Peter, 2015). The approved forms are inserted in the appendices sixteen, seventeen and eighteen.

Given the emerging aspect of qualitative studies, the ethics committee should expect the need for the researchers to introduce changes after having collected some initial data. From a practical view, during the first phase of the study, the main focus was on help-seeking behaviour for sexual problems. The preliminary data were enlightening in that they revealed that sexual disclosure is integral to the meaning women attribute to sexuality and sexual interactions. Accordingly, further exploration of this aspect of their life was deemed necessary to provide a more comprehensive and contextual interpretation of help-seeking. Thus, questions about the meaning women ascribed to

sexuality were added as core element of the study; however, help-seeking became in the background. The core values of ethics are discussed under three subheadings.

4.3.11.1. Qualitative interviewing and protecting vulnerability

Qualitative research is highly invasive in that it probes deeply into the participants' life and privacy. It might also be beneficial for the participants to externalise their problems and get assistance (Agllias, 2011; Peter, 2015). This is equivalent to 'beneficence and non-maleficence', a core value of research ethics (Murphy and Dingwall, 2001, cited in Flick, 2009). It is necessary to anticipate harms although this might be difficult in view of the flexibility and inductive nature of qualitative interviewing. The participants have the right to be fairly treated, distributing the benefits and burdens of the study equally and avoiding neglect, discrimination or any kind of exploitation (Polit and Beck, 2010).

Critical to this ethical principle, the participants were well informed about the study aims, their participation and the ethical principles. They were reassured that their views and experiences are respected and valued considering the uniqueness and individuality of every one of them and the importance of their input to gain insights into the explored topic. Empowering women to talk without judgment contributed to challenge social norms and disrupt the power differences that regulate sexuality. It also incited nurses and midwives to be more reflective in an attempt to promote their role in sexuality-related care.

The interviews were an occasion for women to debrief and for the majority to discuss for the first time very intimate and intimidating situations of their life like their relational problems, being abused or forced to have anal sex and exchanging sex with benefits. All these situations were very impressing and engaging in that women reflected on their deep emotions and sufferings and some of them did not retain their tears. Their emotive insights implied their need to talk and be listened to. Their reflection on their difficult sexual life gave them relief although the interviews were not meant to be a therapy (Then, Rankin and Ali, 2014). One woman said at the end of the interview that she may regret her openness, but she wanted to talk as the problem was taxing on her. Another one avowed participating in the study because someone can confidentially listen to her and understand her suffering. The discussion within the focus groups triggered women to brainstorm about their sexual life, share their thoughts and concerns and support one another. As suggested by Kvale (1996), almost all the participants acknowledged the value of the interviews as a unique opportunity for them to talk and be attentively listened to. At the end of every interview, I checked with the participants the authenticity of their accounts and made sure about their willingness to maintain all that they recounted acknowledging their right to omit what they found inappropriate. But, none of them did so; all approved their talk.

Without playing the role of a counsellor, after the interviews, I spent time with some women who expressed the need to talk about additional concerns they did not want to

include in the interviews. I was deeply affected by some very sad stories and I wished I could be of substantial help to them. Upon their request, I provided some women with the address of a sexologist and accompanied two others to the social worker of the centre from which they were recruited. One participant had suicidal ideas and I referred her to a source of support immediately after the interview.

Besides, all the participants were informed about the risks and advantages of the study and that an immediate positive outcome will not be provided. Their awareness about the real expectation of their participation is important to decide deliberately what to disclose. Nevertheless, balancing the scientific need for collecting data with the possible harm of disclosure was carefully considered. For example, the interview was discontinued with one of the participants after 30 minutes of its start as she felt insecure audio-recording her talk despite the guarantee of confidentiality. I respected her decision and all material related to her participation was immediately destroyed. This asserts some authors' views that woman who does not tolerate being interviewed about some topics decline; if they are comfortable with the interview process, they are willing to talk even if they are embarrassed (Hutchinson, Wilson and Wilson, 1994). Reflecting on the involvement of a participant in her study, Gair (2002, p. 137) also said that 'Overall, the above participant's comments allude to some prior calculations of the risks in becoming a participant and to a willingness to take the risks to pursue personal or collective benefits'.

4.3.11.2. Qualitative interviewing and autonomy/self-determination

This implies the respect of the participants' values and decisions (Murphy and Dingwall, 2001, cited in Flick, 2009). Autonomy/self-determination involves their free consent to participate in the study and withdraw of it at any time without prejudice, allowing the participants autonomy and control over their activities (Polit and Beck, 2010). According to Berg (2001, p. 56), an informed consent is 'the knowing consent of individuals to participate as an exercise of their choice, free from any element of fraud, deceit, duress or similar unfair inducement or manipulation'.

Prior to their participation, all participants received an informed consent form (Appendices nineteen, twenty and twenty one) and were provided with the necessary information concerning their participation and ethical principles. They were asked to sign the consent; some of them refused and consented verbally. This is very common in the Lebanese society where people are afraid to commit themselves by a written agreement particularly when it is about sensitive topics like sexuality. Hawamdeh and Raigangar (2014) argued that a written consent might be problematic for Arab participants as it may be seen as a lack of trust, thus an insult.

The capacity of a person to voluntarily consent to research might be compromised by incentives or the position of and relation to the researcher (Darlington and Scott, 2002; Richie and Lewis, 2003). In this study, I only ensured the transportation of some women

to come to the interviews. However, I was so deeply touched by the precarious economic situation of one woman that I spontaneously offered her some money at the end of the interview. I later on questioned the appropriateness of my behaviour; yet, I came to the conclusion that my intention was good since I was cautious not to infringe the woman's dignity.

4.3.11.3. Thick Descriptions and confidentiality

Through thick description, the identification of a participant might become obvious particularly that a qualitative sample is usually small and its members may belong to the same community (Gibbons, 1975; Richie and Lewis, 2003; Peter, 2015). Berg, (2001) postulates that the violation of confidentiality results in people's reticence to participate in future studies.

In this study, the participants were identified by pseudonyms and the interviews were audio-recorded with their permission. All the transcripts were kept confidential and securely stored in a locked file cabinet. The soft copies could only be accessed by me using a password. Those who did the transcription committed themselves to preserve the participants' confidentiality. Women of the focus groups were asked to preserve one another's confidentiality and privacy. The participants' involvement in the study was also secretly handled and was not revealed to a third party under any circumstances. I also omitted the table that presents the nurses' and midwives' profile and was cautious in

describing their characteristics in the analysis as they know each other since the majority was chosen from the same healthcare setting.

4.3.12. Researcher's concerns and safety

The interviews were tiring and many of them caused me emotional trouble as I had to understand women and contain them. Thus, debriefing with colleagues and my supervisors helped me deal with the emotional impact of these conversations. I was also worried when I had to visit women at home in a neighbourhood I was not familiar with and sometimes did not feel secure. Ensuring my safety when I had to go to the participants' home was a must (Barr and Welch, 2012). Thus, I kept the address of the concerned women in a sealed envelope with an identified person at the university and asked her to call in case I was late. If I had not answered, a series of escalated measures were planned. This was done in consultation with women I visited. However, I had never had any accident.

4.4. **Conclusion**

Informed by a constructionist-pragmatist stance, this chapter presented the theoretical frame that guided the qualitative inquiry about women's sexuality. It was selected as a suitable approach to address the research questions of the study. Based on a constructionist view, sexuality is perceived as a social reality that is relatively interpreted. It is approached from a pragmatist view where its conceptualisation is inherent to the

practical consequences of thoughts. A critical discussion was presented in relation to the interconnectedness of the philosophical worldviews, designs, research methods and analysis processes considering the rigour and ethical principles. Chapter V and VI present the analysis.

CHAPTER V: FINDINGS OF THE ANALYSIS IN REGARD TO WOMEN'S UNDERSTANDINGS OF SEXUALITY AND SEXUAL DIFFICULTIES

5.1. Chapter overview

This chapter starts with a description of the sample of women including their recruitment, purposeful distribution and profile. It is followed by a synopsis of findings about women's understanding of sexuality, sexual difficulties and help-seeking, illustrated by a figure. It then moves on to address the first three research questions. It explains how women's sexual socialisation has shaped their sexuality and led to the expression of a muted sexual self. Then, women' sexual difficulties are presented considering their multifaceted aspect.

Data analysis about help-seeking is detailed in chapter VI while chapter VII presents findings related to nurses' and midwives' perception and experience of their role in sexuality related care.

5.2. Description of the sample of women

In phase I of the study, I conducted 18 individual interviews. I also had one focus group to confirm interpretation and synthesis of the findings of the individual interviews and broaden the understanding of the explored subject (Denzin and Lincoln, 2005; Plack, 2006; Azar, Kroll and Bradbury-Jones, 2016). The second phase included 19 individual

interviews and two focus groups, respecting a certain homogeneity among the members of each group to optimise interaction (Polit and Beck, 2003; Creswell, 2012) and allow for inter-group comparisons. One focus group was composed of only four women although it was expected to include six; two women excused themselves from the interview at the last-minute. The number was still eligible as the sample size of a focus group varies from four to fourteen (Then, Rankin and Ali, 2014).

The different sources of recruitment of women and their purposeful distribution by education and menopausal status are presented in table I and II.

Table I. Sources of recruitment of women

Sources of recruitment	Number of women
Mammography units	16
Primary healthcare centres	11
Obstetrics/ Gynaecology clinics	03
Non-governmental and working organisations	14
Snowballing sample	8

Table II. Distribution of women purposively by education level and menopausal status

Menopausal status	University	Secondary	Intermediate	Elementary and less	Total
Premenopause	9	6	7	7	29
Perimenopause	2	4	2	0	8
Menopause	4	5	3	3	15
Total	15	15	12	10	52

As shown in table III (Appendix twenty two), the total sample comprised 52 women. Their mean age was 47.40 years. All of them were married except for five women, one single, three widowed and one divorced. The women were distributed in terms of educational status with sixteen having enrolled in the university, fourteen had a secondary education (grades 10-12), twelve had an intermediate education (grades 7-9) and ten had an elementary education (grades 1-6) or less. Twenty seven were Christians and the others Muslims, representing the two dominant religions in Lebanon. Twenty eight were housewives and the majority of those who worked outside the home had modest jobs like hairdresser or secretary. Twenty five indicated that they had started the perimenopause or menopausal period.

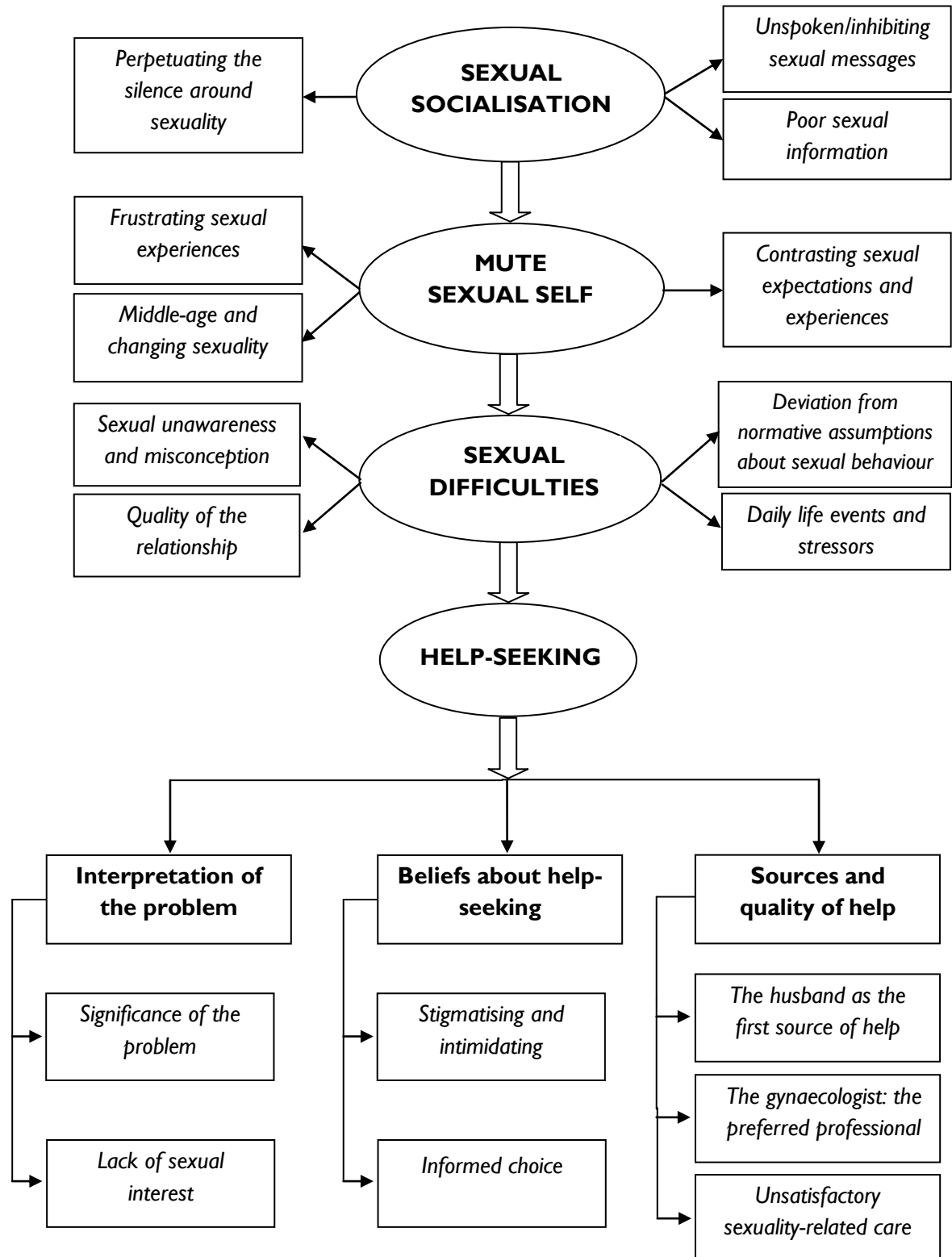
5.3. Synopsis of findings

The women's construction of sexuality was confined within heterosexual normative scripts that reinforce the sociocultural norms, religious values and masculine hegemony. Additional elements that shape women's sexuality were nuanced by women's differing profiles.

Women's sexual self was muted as a result of an inhibiting sexual socialisation that was characterised by unspoken sexual messages and poor sexual information. Sexual disclosure being tabooed, morality around sexuality was transmitted from their parents to the participants. Many recalled the negative feelings associated with menarche and early sexual experiences. It was difficult for them to readily reconcile the incongruent messages of chastity before marriage with sexual pleasure after marriage. Framed in a heterosexual relationship that is legitimate only within marriage, women validated their sexual self through the satisfaction of their husbands' needs. Thus, their sexual relationships were driven by two different views; men's sexuality was portrayed as biological whereas women's as emotional. The participants who reflected on positive sexual experiences were engaged in enabling relationships that provided them with sexual fulfilment and self-confidence. Otherwise, women interpreted sexual difficulties as the result of their lack of awareness about sex life. They also defined these difficulties as male centred, exaggerated by the husbands' resistance to seek help, further asserting men's power and women's mute sexual self. Women identified their husbands as the first source of help. Yet, their

perceptions and experiences of help-seeking were affected by their interpretation of the problem, their husbands' and own beliefs about this behaviour and the sources and quality of help. Findings are illustrated in Figure III.

Figure III. Framework of women's understanding of sexuality, sexual difficulties and help-seeking



5.4. Women's understanding of sexuality

The current chapter that presents findings of the analysis in regards to women's understandings of sexuality and sexual difficulties addresses the following three research questions:

- How do middle-aged women perceive and make sense of sexuality?
- What informs women's sexual views and experiences and how does the construction of sexuality vary in relation to the menopausal status, level of education, religion and occupation?
- How do women describe sexual difficulties and the factors that affect their sexual activities and interactions?

5.4.1. Women's sexual socialisation

'We were the inhibited generation; the generation where you cannot express your feelings...

Our parents were deciding on our behalf' (Dalia)

Sexual socialisation is the process through which women acquired and internalised, across their development stages and experiences, society's beliefs, attitudes, norms and cultural symbols about sexual meanings and expected sexual behaviours. Women reported on the inhibiting sexual messages and poor sexual information they received from their mothers. They also reflected on the intergenerational changes that are nowadays characterised by

an open sexual discourse and permissive sexual behaviours. However, women reproduced with their children their parents' messages and attitudes.

5.4.1.1. Unspoken and inhibiting sexual messages

The content of this section relates to the taboos and stereotypes around sexuality that resulted into women's inhibition.

At the beginning of the interviews, when I asked women about sexuality, almost all of them found difficulties in expressing themselves. They remained completely silent for a while showing their embarrassment, astonishment and confusion. It appeared that they did not know what to say and how to say it. Even the participants of the focus groups waited for one another to initiate the discussion and give hints to one another. I had to give women time to reflect on the topic and to probe them in many ways to talk. Then, they explained that sexual disclosure is unusual for them. Many avowed that they had never thought about their sexuality, what it is and means for them, although it is part of their daily life. Women's timidity to express themselves is represented by Jana's quote: *'The person who has a conservative upbringing does not like to talk about the topic' (Jana)*. Women linked the silence around sexuality with their generation where discussing sexual issues was considered to be promiscuous. For this age group, sexuality was completely unspoken. It was experienced quietly within marriage. This was one of the explanations provided by some participants to justify the reluctance of the woman in the vignette to

talk about her sexual issues even if the discussion was with a healthcare professional and for sexual health purposes.

Fadwa. It is her upbringing (woman of the vignette); she was brought up not to talk about sex. This woman is 49 years old. In the past and I too experienced this, we did not discuss sex in the family. We were forbidden to talk about the topic.

تربيتها، ربيت ما تحكي بالسكس. هيدي المرأة عمرها 49، من قبل وأنا مرنت فيها كمان، ما كنا نحكي موضوع السكس بالعيله. كان ممنوع نفتح هيدي السيره.

Women added that sexual oppression and taboo are particularly inherent to Middle Eastern societies. Thus, the allusion to sex or sexuality was absent in family life as articulated by the dialogue of women of the focus group 2 (FG2):

Racha. We also lived in an atmosphere where there was not a lot of this (sexual life); we did not see life between mom and dad... we felt that woman is only for reproduction and not more than this...

عشنا ببينة و بجو كمان مثلاً ما في كتير هيك (حياة جنسية) ما شفنا حياة بين امي وببي... حسينا ان المرأة خلص المرأة هي بس للانجاب ان مش أكثر من هيك.

Sally. We do not have the understanding of sex. This is not part of our culture, our upbringing.

نحن ما عنا مفهوم الجنس. هيدا منه جزء من ثقافتنا، من تربيتنا

Racha. We did not have this culture; even up till now. If I was not in a school where they were open to the topic, I would not have known.

ما كان في هيدي الثقافة، لحد اليوم يعني. انا لو ما كنت معلمة بمدارس كتير بيعطوا، ما كنت بعرف.

Tressy. Mama did not tell us. In the past, they did not tell.

ما قالتنا الماما ايه، من زمان ما كانوا يقولوا.

Razan. Eh, nobody told me that there is an opening for sexual intercourse ... I was not young when I got married; I was 20. Imagine that at the age of 20, I did not know that there are two openings?! (Urethral meatus and vagina).

اياه ما حدا قللي إن في مطرح الوحدة بتتزوج فيه. انا ما تزوجت زغيرة . كان عمري 20 سنة. تخيلي انو الوحدة عمرها 20 سنة ما بتعرف انو في مطرحين.

Women remembered the prohibiting messages they received, internalising sex as something scary and unpleasant. Carmen interpreted these messages by saying:

Carmen. Be careful; dress conservatively... Behave properly... Do not allow boys to touch you... These are confusing and laden messages for the girl. You give the girl unclear messages that evoke in her an unhealthy curiosity about this topic... there is inhibition, privation, marginalisation... there was decency then, shame; you shouldn't wear short clothes, it was shameful to show your breasts. All these issues were in my head.

انتبهي، البسي بحشمه... تصرفي مضبوط... ما تخلي الصبيان يلمسوك... هودي "مساجات" هودي رسايل مبطنة للبت،... بنصير بنعطي رسايل غير واضحة للبت، ما بتعمل غير توعي عندها الحشوية الغير سليمة بهالموضوع... في كبت، حرمان، تهميج... في حشمه كان، عيب. ما بتلبسي قصير، عيب ما بتبيني صدرك. فكله هيدا كان براسي.

Sexual messages, if any, were focused on reproductive purposes and men's needs.

Elham. You are brought up with the idea that you need to have children and be a housewife...

You have to be there for him... You have nothing else to think about and this is wrong...

بيوجهوك بالتربية إن إنت لازم تجيبي ولاد وتكون ست بيت... بدك تكوني موجوده كرماله... ما عندك شي ثاني
تفكري فيه وهيدا شي غلط.

Paradoxically, and as recounted, it was a shame on women if men would have admiring looks for them that were reciprocated. Many families imposed the social gender segregation where women were required to be invisible in the presence of men.

Kamal. I do recall when I was a child; I was the oldest of my siblings. I was forbidden to stay on the balcony. When my brothers' friends were visiting us, we were not allowed to stay with them... maybe because of the upbringing and inhibition that we lived in we knew nothing about sexual life until we got married...

أنا مذكره على صغر كنت أنا الكبيرة بإخواتي، ممنوع أوقف على البرندا. كانوا إذا إجوا رفقات إخواني الشباب،
كان ممنوع، كان ممنوع نقعد معن... يمكن التربية والكبت يالي كنا عايشينه، ما بنعرف شي عن حياتنا الجنسية إلا
لما تزوجنا...

In support of her conventional upbringing, Kamal repeated her father's instructions by saying:

Kamal. My parents' upbringing was so severe and I was afraid of my dad... From your husband's house to the cemetery (what her father was telling them); my dad's mind was like that.

عند أهلي كثير تربيته (صارمه) وأفزع من بيبي... من بيت زوجكن للقبر. هيك بيبي عقله.

The low self-esteem was an additional limitation induced by women's upbringing.

Mada. Mum raised us in this way; we are worth nothing. We are here just to make others comfortable. That is why I have a very weak personality... We were raised in a household where we did not have any value... If you are dying you have to meet your brother and father's needs and serve them

لأن أمي ربنا هيك، نحن ما لنا لزوم، منريح غيرنا. كرمال هيك أنا شخصيتي كثير ضعيفة... ربينا ببيت ما كان لنا ولا قيمة... لو عم تموتي بدك تقضي أغراض خيك وبيك وتخدمهم.

Women's devaluation and the notion of doing sex for the other's satisfaction was supported by the religious beliefs as internalised by Mada who is a Muslim housewife with low education.

Mada. He's the man. We have this understanding that when the woman refuses this thing (sex), he marries someone else. It is that easy... This is the mentality. When the woman gets older and refuses this thing, he gets married; he brings the surrogate. I fear God; they say that it is "Haram" (a sin in the Islam Sharia) to refuse the man even if you are dying.

لأهلاً هو الزلّة عنا المفهوم إن وقت المرأة ترفض هالشىء بيتزوج عليها سهلة كثير... إن نحنا عنا هيدا
 المفهوم. بس المرأة تكبر وترفض هيدا الشىء بيتزوج، بدو يجيب البديل... أنا بخاف من الله، بيقلوا إن هيدا
 حرام الزلّة ترفضه، لو كنت عم تموتي يعني

The sacrificing role was very common among women, following the behaviour their mothers had 'modelled' for them as exemplified by the narrative of Hana who is another housewife Muslim woman with secondary education.

Hana. Mum raised us in a way; mum has always devoted her life to us. I do not know, I do not know. By nature, the woman likes to sacrifice. Have you noticed how she sacrifices for her household, her children; this is her constitution.

بعدان إمي مربايتنا بطريقة إمي كل عمرها حياتها لنا. ما بعرف ما بعرف. هي تكوينة المرأة بطبيعتها بتحب
 تضحي. إنت لاحظتة كيف بتضحي تجاه بيتها تجاه ولادها. هيدا من تكوينتها

As the discourse about sexuality was unusual, women reflected on their poor sexual information.

5.4.1.2. Poor sexual information

Women's accounts in this section report on their lack of sexual awareness and preparation to meet sexual life requirements. They acknowledged the role of the media in introducing intergenerational changes and openness. Women demonstrated scepticism

towards contemporary media sources and felt that these presented a biased picture of sexuality.

Many women repeated the sentence '*Mum did not tell me anything; she never told me...*'. The discussions that took place between the mothers and their daughters— if they took place at all — were considered shameful or sinful, even if the intention was to educate them about sexuality. '*It was a shame asking a question and they were not orienting us*' (Fadwa). Thus, when Odile had the courage to ask her mum '*where do babies come from*', she was beaten. Sexual discourse was seen as provocative unless it had a warning purpose to protect their daughters against male gaze. Sexual messages, imbued with double standards, were mainly conveyed by the mothers as recounted by Beatrice, a menopausal housewife with secondary education:

Beatrice. I have always been told by my mother that a man is a man; yet, a woman is vulnerable. Think with me; it is true. The man does not care. He goes out, flirts and sleeps with women since his early age. The woman does not search for sex unless, pardon, she was promiscuous. Usually, these women's bodies need sex. They go out on the streets and look for it. This is a disease, a disease. However, an honest/decent woman takes care of her children, her house and does not ask for sex... However the man cannot; he has to go out... The woman should be careful; she cannot risk her reputation...

إمي كل عمرها كانت تقللي الرجال رجال بينما المرأة معرضة. فكري معيك مضبوط. الرجال ما بتفرق معه. بده بيرم من أول شبابه. بيتحركش، بينام مع نسوان. المرأة ما بتبرم على السكس إلا إذا شي واحد، "باردون" يعني الفالته عالطريق. هي هيدي الفالته بيكون جسمها بده سكس. بتقلت عالطرقا، بتصير تتلقط. هيدا مرض، مرض. . . بينما الست الآدمية، ضابه أولادها، بدها بيتها، ما بتطلب سكس. . . بينما الرجال ما بيقدروا بده يروح. . . المرأة لازم تنتبه، ما فيها تخاطر بسمعتها...

The school had a limited role that enhanced the ideal sexual behaviour as socially scripted. Friends' support was not efficient as their information was poor and inaccurate. Quinda who has a secondary education said that:

Quinda. The school was not at all concerned by this topic (sex). Initially this was shameful; how can the school highlight the topic? No, no; this was not acceptable in the society and the parents would have refused it. They were crazy when they saw a boy and a girl together. We did not even stay next to the boys in class.

المدرسة ما كانت معنيه بهيدا الموضوع (الجنس). أصلا " هيدا كان عيب، كيف ممكن المدرسة تحكي بهيدا الموضوع؟ لا، لا، هيدا ما كان مقبول بالمجتمع والأهل كانوا رفضوه. ما دام كانوا إذا يشوفوا بنت أو صبي مع بعض، يخوتوا. كنا حتى ما نقعد حد الصبيان بالصف.

Women with few resources reflected on the difficulties in gaining access to sexual information. This was depicted in Bahjat and Mada's accounts, two housewives with low education:

Bahjat. It is not easy to find information... asking someone! No. it is not easy; we were nurtured in a conservative society where everything was taboo. We live in an environment where nobody talks about sex. Everything is taboo. We never discuss this topic. There is no openness for such a discussion... I do not know a lot about the subject... But I never thought about this issue (to get information)...

مش هين فتش على معلومات... مع حدا لاء مش هين لأن البيئة يالي عشناها كلها بالحياء. عايشين إن ما حدا
بيحكي بالسيرة الجنسية. كلها حيا بحيا. خلص هيدا الموضوع ما بنحكي فيه. ما في إنفتاح لهيدا الحوار... أنا ما
كتير بعرف... بس ولا مرة فكرت بعالشغلة...

Mada. The fact that the woman is at home is different. She does not have access to anything. It is not easy to get information about sex. I do not have a car and I do not have the freedom to go whenever I want... I cannot enter a bookshop and buy a book about sex with confidence. I do not have access to things...

لأ هلا إن كون المرأة بالبيت غير، ما بيوصل لها شيء. منه هين تحصل على معلومات عن الجنس. ما عندي
سيارة وما عندي حرية أضر وقت يالي بدي... ما بقدر فوت عالمكتبة وإشتري كتاب عن الجنس بكل جرأة. ما
بقدر أوصل لشي...

Many women avowed that the discussion with them awaked their curiosity to develop their sexual information as they had never read anything about the topic. Conversely, some others preferred not to alter their innocence as sex is a spontaneous behaviour as articulated by Nay, a housewife with low education.

Nay. ... Concerning the books, I do not know if all that they write is accurate and correct. But we as human beings follow our common sense, what does not harm us... I do not rely on the knowledge per se; this (sex) is inherent to the nature of human beings. I rely on what is comfortable for me, what are the norms that relate to me, our religion (Islam), upbringing and the nature of human beings...

... بالنسبة للكتب ما بعرف إذا كان يلي بيكتبوا كله مزبوط وصح، بس نحنا كبشر إنو منلحق إنو شو بدنا، شو يلي ما بيؤدنا، هيدا يلي منلحقه يعني، أنا ما بعتمد إنو على العلم بحد ذاته، من طبيعة البشر يعني،... بعتمد شو يلي بيرحني أنا، شو الأصول يلي عندي أنا وديننا وبتربايتنا والطبيعة البشرية...

Women did a comparison between their own and current generation highlighting their poor sexual information versus the nowadays openness and easy access to resources through schools, universities, books and magazines. They particularly acknowledged the role of the media in breaking the taboo around sexuality. However, they expressed their reservation towards some forms of media as they are daring and not culturally sensitive, affecting children and adults perception about sexuality as discussed among the participants of the confirmatory focus group:

Uguette. Young boys and girls who are aware know where to get their information from. But there are some things that are vulgar; things which are disgusting. I mean not normal...

الشباب أو البنات الواعي بيعرف من وين بياخد معلومات. بس في إشيا بزيقة. يعني بتقرفك بالحياة. يعني غير طبيعية...

Some things that are being shown are not normal. Many things are programmed to attract the audience and buy the movies... youth should be aware and know from where to select the resources

في إشيأ عم تنشاف منها طبيعية، مبرمجة لأن يوصل هالمشاهد إن يعشق هالأفلام ويشترها. . . الوعي هو إن الشباب يعرفوا من وين ياخدوا معلوماتن. . .

Widad. This is the responsibility of the parents... I mean you have to make him (the child) aware. Pornographic movies distort the sexual relation...

هيدي توعية الأهل. . . يعني إنت بدك توعيه. . . أفلام إباحية هيدا تشويه للعلاقة الجنسية. . .

Uguette. This does not mean that if a woman watches such movies she should claim that her husband is not normal.

مش إن وحدي تروح تحضر هيك فيلم وتقول جوزي مش طبيعي.

Sawsan interrupted and said: man asks a lot of things of his wife (perceived as perverse). He watches and tries...

الرجال بيطلب إشيأ كتيره من مرتو. بيتفرج وبيجرب

The majority of the women interviewed believed that being sexually informed is necessary to develop a positive perception of sexuality, gain agency and get a healthy sexual life without intimidation or inhibition. Sexual education was perceived as a protective measure against physical, psychosocial and sexual health problems like sexually transmitted infections, unintentional loss of virginity, rape and unwanted pregnancies. For instance, Elham assumed that she would not have been divorced if she was more aware

about sexual life. The participants of the focus group I (FGI) who were all highly educated discussed the importance of sexual education; some of their statements included:

Nadege. I mean, sexual health is part of sexual education. We have to start first with sexual education, from a young age, as soon as the body starts transforming... when I was teenager, I liked to ask and know everything... the way I am growing because I assumed that one day I will become mature and maybe a spouse and mother... knowledge helps you negotiate and impose yourself...

يعني الصحة الجنسية هي جزء من التربية الجنسية. أول شي لازم نبش فيا التربية الجنسية، من الصغر من أول ما يصير في تحول بالجسم... وقتما كنت تين أيجر يعني كنت حب اسأل وأعرف كل شي... أنا كيف عم بنمى لأن أنا بيوم من الايام راح صير ماتور ويمكن زوجة وإم... المعرفة بتخليك تاخدي وتعطي وتفرضي حالك...

Mirvat. This relates to sexual education

هيدا بيدخل بالثقافة الجنسية

Nadege. Sexual education is an essential part of sexual health

الصحة الجنسية "بارت" كتير مهمه منها هي الثقافة الجنسية

Tamara. In sexual life, there should be acceptance of the other... within the standards of a healthy/good sexual life... I have to know the other to see if I sexually accept him or not... this is the healthy and correct sexual relation... even emotionally and socially, sexual relation affect all these factors... it is not only about a bed and another person; not at all. This requires awareness... Sexual education is very important to understand yourself and others...

بدء يكون في قبول للآخر بالحياة الجنسية... ضمن معايير الحياة الجنسية السليمة... يكون عندي معرفة للآخر لأقدر انقبلو جنسيا" أو لا... هيدي العلاقة الصحية الصحيحة... حتى نفسيا واجتماعيا حتى بكل هالعوامل بتدخل فيها العلاقة الجنسية... مش إن هو بس الواحد يكون في تحت وعنصر آخر، أبدا". هيدا بدء وعي... التربية الجنسية كتير مهمة حتى تفهم حالك وغيرك...

Mirvat. Sure, sure, sexual education helps you to know everything that you might be exposed to in your life... I was exposed to many difficult issues in my marital life and sexual relation (because of infertility problems)... What helped me was my love for knowledge...

وأكد اكيد، الثقافة الجنسية بتساعدك تعرفي كل شي ممكن أنت تتعرضيلو بحياتك... إن أنا كتير تعرضت بمسيرتي الزوجية والعلاقة الجنسية لكثير إشي، وكثير إشي صعبة (بسبب مشاكل العقم)... يالي ساعدني إن أنا بحب كتير اتطلع...

As these women had inadequate sexual information as a result of lack of communication with their parents, one would expect that they would behave differently with their children thus avoiding the perpetuation of sexual inhibition. This did not seem to be the case as the intergenerational sexual communication remained uncommon for the majority of the participants.

5.4.1.3. Perpetuating the silence around sexuality

Underlying women's accounts in this sub-theme are their limitations to provide initial sexual education and adequate sexual socialisation to their children, perpetuating their parents' approach with them. The lack of knowledge and preparedness was the main

barrier for women as sexual disclosure is a taboo issue and conversation about sexuality is considered shameful.

Parents' role in sexual education was mainly encouraged by the highly educated women to control the content and approach. For instance, Nadege, BS in biology, said:

Nadege. The school, where children spend three quarters of their life and time provides more than 50% of their basic ideas because of their friends. But it is the home environment that determines how sexual education is transmitted not the school. It is not the information that the child hears from here and there; it is rather the authority that is important. The parents are the one and only reference.

هلق المدرسة يلي ثلاث ارباع الوقت الولد بيصرف فيها حياته ووقته هي اكثر من خمسين بالمية من الـ "باز" للأفكار لأنو في الرفقة. بس البيت هو يلي بيقرر كيف يبني ثقافته الجنسية مش المدرسة. مش كترة الحكي والكلام يالي بيسمعه من هون ومن هون. "الأوتوريتي" هي يالي بتأثر، الأهل هني المصدر الاول والنهائي.

Two participants, Faten and Lea, confirmed their inability to provide their children with sexual education although they had a university degree and were aware of the importance of parents-children sexual communication. Instead, Faten brought her daughter a book about the physiology of human reproduction and Lea relied on the support of her gynaecologist. As for Razan, a participant of the FG2 who had an elementary education, her approach with her children was:

Razan. Really, my daughter asked me when she was 12 years old. My children asked me 'how does the woman get pregnant?' I told them 'I do not know'. How I can answer this question to a young girl! My youngest son asked me 'Mom, how did you give birth to me?' I told him 'mom the doctor came; he opened my abdomen and got you out'. I still have traces of the operation. I showed him the scar of the surgery. We do not have the courage to talk with our daughters about sex.

عن جد أنا بنتي سألتني كان عمرها 12 سنة. مرة سألوني ماما كيف بتحبلى المرأة؟ قتلتن ما بعرف. طيب كيف بدي
جواب هيك شي لبنت صغيرة. قام هيدا الزغير ابني قللي ماما انت كيف خلقتيني؟ قتللو ماما اجبا الحكيم فتحلي
بطني وطلعك. العملية مبينة، فرجيته ياها. ما في عنا الجرأة نحكي مع بناتنا بالجنس.

Razan's statement was contradicted by Sally, a psychologist in the same focus group. She insisted on the necessity of children's sexual education in a progressive way to facilitate the adaptation to developmental changes. As such, she has already prepared her nine year old daughter for the menarche. In contrast, three participants strictly refused to have any sexual communication with their daughters although they expressed the need to get enlightened before marriage. Some found that nowadays children do not need their parents informational support as resources about sexuality are widely available. Others considered sexual discussion as immoral and silence was adopted as a protective measure against their daughters' sexual temptations, thus emulating their parents' behaviour. Elham whose daughter was entering adulthood said:

Elham. I cannot tell my daughter, 17 years old, everything; I am too shy to do it. I do not like there to be insolence in my relationship with my daughter. She has to exhibit some shyness, good manners and politeness. If I give her details, she might like to try. In this way, she will have fear... No, no, you cannot be very clear. Even American people are not very clear. They let their children discover by themselves.

أنا ما بقدر خبر بنتي، 17 سنة، كل شي. ما بقدر خجلا"، ما بحب إن يكون في وقاحة بعلاقتي أنا وبنتي' بيدم عندها خجل، أدب، وتهذيب لأن في إشيا إذا بدي فوت فيها بالتفاصيل يمكن تحب تجرب هالبنت. هيك بيدم عندها خوف... لا لا ما فيك تكوني كثير واضحة. حتى الأميركيان ما كثير واضحين، بيخلوا أولادهم يكتشفوا لحالهم.

Sexual socialisation seemed to be more challenging for the participants with their sons. To surmount their intimidation, they referred them to the father whose role was negligible.

Elham. I ask his father to talk to him, because how can I do it myself? What will I tell him? I am embarrassed with my son.

بس أنا بحكي بيه حتى يوعيه لأن كيف بدي وعي إبني؟ شو بدي قلله؟ بخجل مع إبني.

Karine who accused her husband of sexual problems was motivated to warn her son, when he gets married, to be responsive to his wife's sexual needs. As for Odile who was proud of her openness with her son, she cautioned him of the adverse effects of

masturbation on his health and gave him warning messages to avoid sexually transmitted infections.

The lack of parents-children sexual communication seemed to be reciprocal as highlighted by two women. Their daughters were equally uncomfortable to discuss sexual issues with them.

5.4.2. Mute sexual self

'Women who were brought like us are not concerned by these issues (Oumaya)

Conceived within a sexual socialisation that reinforced the normative expectations and silence around sexuality, women's sexual self is mute. Their sexual self-perception, expectations and experiences resonate within sociocultural scripts and social myths that result in difficult experiences and sacrificing roles. The normalcy of sexual behaviours and the affection between the spouses were essential conditions for women to express their sexuality. However, their lived experiences contrasted with their expectations. They had frustrating and inhibiting sexual interactions. Their sexual life was governed by men's power and their own submissiveness, leading to a 'mute sexual self'. This was exaggerated by the negative perception of the changes that may happen at middle-age and in relation to menopause.

5.4.2.1. *Frustrating sexual experiences*

Data in this subtheme reflect on women's negative feelings and experiences when they were confronted with life events like menstruation and marriage due to their lack of sexual awareness.

The face-to-face interviews and focus group discussions were for the women an occasion to criticise the silence around sexuality equating it with shame and causing their clumsiness when faced with developmental life changes and transitional events like the onset of puberty and the entry into marital life. The discussion around the topic required little probing as women were so vocal in expressing their fear, ambiguity, guilt, low self-esteem and inhibition due to their sexual ignorance. In the focus group discussions, I often had to intervene to calm them down and impose some rules as they were talking over each other and approving each other's opinions.

Inass described at length her massive embarrassment when she unexpectedly got her menarche and was not at all aware of this developmental change. When she went to her mother for reassurance, the latter was only concerned with warning Inass about preserving her virginity since at this age she might become subject to sexual temptation. Inass' story represents the case of almost all the participants who internalised virginity as an indispensable requirement for marriage. Inass remembered that:

Inass. In our upbringing, no, it was forbidden (sexual discussion). We were not even aware about menarche. In the past, I was not aware; our parents' mind was like that (not open). I mean, we do not for example inform the girl that one day she will get her period until the time comes. Let me tell you about myself. I was at about 12 years and a half. My sister is older; but they did not allude to the topic. I went to the toilet and saw blood. My mom called me when she noticed that I used the toilet at about 9 times. I told her I do not know what happened to me. Then, she informed me that now I got my reproductive maturity and I have to be careful about myself.

نحن تربيتنا لاء ممنوع. الواحدة منا حتى ما كانت تعرف ميعاده ا. ما كنت أعرف مثلاً" من زمان، الأهل هني هيك عقلاتن، إن ما بنخبر مثلاً" البنت إن يوم من الأيام بده يصير عندا "البيريود" إلا ليحي الوقت. تخبرك عني أنا. أنا كان عمري شي 12 سنة ونص. عندي أخت أكبر مني بس ما كانوا يجيبوا سيرة ويحكوا. فتت على تواليت شفت في دم. صرت فوت وأضهر عالتواليت شي 9 مرات، انتبهت الماما، عيطت لي. قلت لها مضري شو صاير معي، إجت فهمتني هيك هيك إن البنت بلغت، لازم تنتبهي على حالك.

Faten, a highly educated woman, reported the feeling of terror and rejection of her parents and married sister when she accidentally knew what happens when people get married (sex) although she was at her late adolescence. She perceived them as immoral and sinful since she had in mind that sex is shameful and a bad social behaviour like smoking, drug addiction or alcoholism. Faten associated sexuality with a feeling of culpability that was nurtured at childhood and adolescence and was seriously manifested at marriage. She described this feeling as painful and hard to forget. Faten's experience

seemed to be common to at least half of the participants who extensively reflected on their awkwardness when they got married as the result of their inappropriate sexual socialisation. In this respect, Elham reported:

Elham. The girl grows up scared since she knows nothing. Thus, she will be uncomfortable in her life; she does not know how to treat her husband or how her husband should treat her because she doesn't understand anything about sexual life... this is terrifying!

البنات بتكبر بيخوفها، منها عارفة شي من شي. لا بتكون مرتاحة بحياتها، لا بتعرف كيف بدها تعامل زوجها ولا بيعرف زوجها كيف بده يتعامل معها لأن بتكون مش فهمانه شي من الحياة الجنسية ومتطلباتها... هيدا الشي مرعب!

Three women described at length their traumatising feelings when they saw their husband naked. They did not readily realise his anatomic configuration as a man. Carmen, a highly educated woman who got married in her late twenties, reflected on her experience by saying:

Carmen. When I got married, my husband was the first man in my life. I had never seen another one. Actually, I had never even seen a man. I did not know and did not imagine what he might look like. When I saw him and now I took it as a joke, I told him 'what is this?! What do you have over there? What happened to you?! What is the matter?! [alluding to his genitals]...' eh, and I couldn't; I couldn't have sex ...

يعني أنا وصلت لعند زوجي أول رجال بحياتي، ما شايفه غيره، ما شايفه رجال أصلاً". ما بعرف يعني ولا مفكره كيف ممكن يكون، بضحك بس يستعملها نكتة، إن أول ما شفته صرت قللو شو طالعلك يعني، شو بك؟ شوفي؟ إيه وما قدرت. ما قدرت مارسست الجنس...

Raja discussed this frustrating experience with the participants of the FGI explaining that:

Raja. ... But I feel and behave the way I believe. If I believe that this relation is a shame it is shameful to stand naked in front of a man... Initially, you are too shy to look at your body, you cannot look at your body. Suddenly, you find yourself alone with a man. The experience might be scary...

بس هي انا كيف بعتمد بصير بحس وبصير اتصرف. فإذا انا اليوم بعندي عم بعتمد انو هيدي العلاقة عيب، عيب انو انا اوقف ادم شاب... يعني انت اصلاً بتكوني مستحبة انو انت تكوني مع حالك تتطلعي عحالك. بتلاقي فجأة انو انت صرتي مع رجال لحالكن. ممكن التجربة تكون مرعبة...

This might justify Mirvat's timidity to express her sexual likes and dislikes to her husband although both of them are highly educated (she is a journalist and he is a physician) and very attentive to one another's needs.

Mirvat. Our relation is very nice... there is nothing hidden between my husband and I... but in this subject specifically (sex), I always feel that no, I cannot tell him this is what I like. I cannot tell him. I am shy... We spend an evening together, ... we caress one another... up to the

point where you might not any longer feel that there is a woman and a man caressing one another; as if it was a mom who is caressing and cuddling her son. This is just to show you the extent to which we might be close to one another. But, when we arrive to bed, I like to turn the light off and he likes to keep it on. I cannot tolerate the idea that he is looking at the details of my body; I cannot.

كثير حلوة علاقتنا، ... ما في شي مخبي بيني وبين زوجي، ... بس بهيدا الموضوع بالذات دايمًا بحس إن لأ أنا ما بقدر قللو أنا هيك بحب. ما بقدر قللو، بخجل... بنكون سهرانيين مع بعضنا، ... بنغنج بعضنا ... بشكل إن يمكن ما بتعودي بتحسي إن في مرأة ورجال عم بيغنجوا بعضن، كأن أم عم بتغنج ابنها. شوفي لأي درجة ممكن تكون حميمة طريقة الغنج والعكس صحيح. بس لما بنوصل على التخت أنا بحب الضوء مظفي وهو بيحب الضوء مضوا، أنا ما بتحمل الفكرة إن عن بيشفلي تفاصيلي على الضوء المضوا، ما بقدر.

Women's awkwardness could have rendered them easy sexual victims to their husbands. Yet, the latter seemed to be understanding and supportive during that time. Quinana, a housewife, with a low education level reported:

Quinana. My husband was the first person in my life ... He was annoyed because I did not know anything. But he taught me ... I was not at all aware about the subject ... I mean if he had asked for the impossible I would have done it because he knows and I do not know.

أول شخص كان بحياتي كان جوزي ... هو انزعج لأن ما بعرف شي. بس صار يعلمني ... بس أنا ما عندي فكرة عن الموضوع أبداً". يعني لو كان طلب المستحيل حتى، كنت بعمل لأن هو بيعرف أنا ما بعرف.

Quinana added that she was totally submissive and ready to respond to all of her husband's demands to avoid his embarrassment. Raja, who has a university degree as a life coach, called women to become empowered and be proactive in imposing themselves and determining their sexual life. Reflecting on her own experience and the way she clearly and assertively requests what she wants, she said: I tell him (her husband) '*I need to go out rather than you do not take me out*'. She presumed that men notice if a woman is comfortable with her body; she cannot ask him to see her beauty if she, herself, does not see it. Others, like Gabby, Pamela and Nada, proudly reflected on their successful sexual relation; they cautioned women to privilege this aspect of their life as sex is pleasurable and gives self-confidence. However, the majority of women did not hesitate to sacrifice prioritising their husbands' needs over their own expectations and aspiration to an ideal sexual life.

5.4.2.2. *Contrasting sexual expectations and experiences*

Conceived within a heterosexual relationship, the heteronormative social perception of sexual interactions, this subheading stemmed from women's expectations for a good sexual life governed by their spouses' empathy and exchange with respect to the 'normalcy' of the sexual act. These expectations are confronted with sexual experiences that are gender-based and driven by men's power and women's sacrifice to maintain the family bond.

Women described sexual life as an essential component of one's life. *'It is a necessity for the growth and development of the body and spirit'* (Carmen). Other accounts like *'A balanced and healthy person should have a balanced and healthy sexual life'* (Asma); *'If your sexual life is good, your overall life is good'* (Ibtissam); *'Sex is nice and pleasurable'* (Dalia); strongly affirm women's need for a satisfying sexuality. The inevitable need for sexual life was expressed by the terminologies *'must, necessity, essential, important, everything in life, like water and food...'*

The participants also evoked the need for reciprocal exchange, harmony and transparency between the two partners to better know and accept one another. They stressed the consideration of women's sexual needs and preferences rather than having sex imposed on them as it was revealed by their narratives. Dima, a highly educated and active woman declared:

Dima. This thing (sexual life) is emotional and physical; spouses express in this way (sex). It is so difficult for woman to accept (sex) if she is not physically and psychologically well. This depends on their harmony even if religiously it was a duty (Muslim). If you are comfortable, happy with your husband, you feel that sexual relation is normal. If you are not comfortable, you feel that as if you are being stabbed.

هيدي الشغلة هي عاطفة مع شي جسدي بيعبر عنها الزوجين بهالطريقة. صعب تقبل إذا مش مرتاحة نفسيا". مدى تفاهمهم مع بعض، هيدا يالي بياثرحتى لو كانت واجب بالشرع. إنت مرتاحة مبسوطه إنت وزوجك بتحسي العلاقة الجنسية طبيعية. لما ما بتكوني مرتاحة بتحسي كيف الواحد عم يضربك بالسكين

Lea's also stated:

Lea. Sex is not something that you do mechanically just to get it done. If there is no arousal, the woman will not get excited. The touch, the word, everything affects woman, even if she does not feel like it. I am talking about myself.

هو الجنس مش يالا خلص وخلصنا بقي. إذا ما كان في مناغشه ولعب، المرأة ما بتتحرك. اللمسة الكلمة، كل شي بياثر بالمرأة حتى لو ما كان جايي على بالها. ما بعرف عم إحكي عن حالي.

Women's expectations to have a warm sexual life were often confronted by the husbands' lack of cooperation and an inhibited communication between the two spouses, thus, having sex instinctively.

Dalia. I'll tell you what the problem is. The problem is that my husband does not give me affection to entice me to sleep with him. I am so emotional. I need to be caressed, to feel my husband. I need affection, interest; this does not exist. He does it and turns his back to me.

أنا بقللك شو هي المشكلة. المشكلة إن الحنان الموجود بجوزي إن يرغبني فيه حتى نام معه، ما في. يعني أنا طبيعتي مشاعري، أنا بحب المشاعر كثير، إن قبل الجنس. إن حتى حس بجوزي مضبوط ، بده يكون عندي مشاعري، إن حنان وإهتمام، إيايه، ما في. بيعملها ويبيرم ظهره.

I asked her: you do not talk, discuss together. She answered:

No, no (we do not talk). He does not care. But, I am his wife, not anyone; you know what I mean (not his mistress). Ouf! I have feelings and I need kindness, affection, love, love, love. He never says something nice, anything, anything to arouse me. But I am not like that, I am romantic [she laughs]. At the beginning (of our marriage) we were not like that; I was happy with him. He was so affectionate but now he does not care. You know, I prefer not (having sex with him). It is so difficult; this is difficult for a woman, you know? Sorry to say it, but he is taking advantage of me. I can sacrifice, but not in this way!?

لا، لا (ما بنحكي)، ولا بيهتم. إن أنا مرتو مش حيلأ حدا، بتعرفي شو بعني. أوف! أنا عندي مشاعر وبحاجة لعطف، حنان، حب، حب، حب. أبدا"، ما بيقول شي حلو، حيلأ شي، حيلأ شي يرغبني. بس أنا مش هيك، أنارومانسية [تضحك]. فيالبداية (منزواجنا) كنا غير هيك وكنت مبسوفة معه. كان حنون كثير. هلق ما بتفرق معه. بتعرفي، بفضل لاء [ما أعمل جنس]. هيدا صعب، صعب عالمرأة، بتعرفي؟ سوري قولها بس أن متل واحد عم بيتأ الثاني. أنا ممكن ضحي بس مش بهيدي الطريقة.

Within the same context, many women insisted on the respect of the 'normalcy of sexual act' which is defined by vaginal sexual intercourse. Otherwise, anal sex was perceived as

dirty and unhealthy. This conception was particularly expressed by the Muslim women as anal sex is forbidden in Islam as revealed in the dialogue of women of the FG2:

Tressy. Hygiene from the part of the two partners and the correct and natural relation (vaginal sex)

النظافة من الشريكين والعلاقة الطبيعية المظبوطة

Razan. That does not include perversion

يالي ما فيها شواز

Tressy. You see on facebook a lot of perversion and repugnance in the relations... For me, the correct sexual life is a healthy one that is socially accepted

بتشوفي كثير إشيا أوقات على "الفيسبوك" كثير في شواز وفي قرف بالعلاقات... العلاقة الصحية المعترف فيها والنظافة، أنا هيك بعتبر الحياة الجنسية المظبوطة

Razan. When there is anal sex between man and woman, things become disgusting and unhygienic. In our religion, if a man would like to have anal sex with his wife, she becomes legally divorced. The sheikh does not return her to him. In addition, this is not good because it is not hygienic. This is a perverse situation.

بيصير في علاقة بين الزلمي والمرأة من ورا بتتطور لشغلات قرف ما فيه انظافة. هيدا بالشرع نحن ديننا إذا الرجال بده يقرب عالمرأة من ورا بتصير طالق شرعا". الشيخ ما بيعود يردلو ياها. وأول شغله، منها مليحه وما فيها نظافة. هيدي حاله شاذه.

Tressy. There should be respect to the partner and hygiene and this thing does not happen by force

إحترام الشريك والنظافة ومايصير الشي بالقوة

Sally. Sometimes, something disgusting happens which means that there is no a healthy sexual life to begin with. There is disgust... In relation to our Muslim society, God set permissions and interdictions...

بس أوقات بيصير في شي مقرف يعني ما في صحة جنسية أصلاً". صار في قرف... نحن بالنسبة لنا بمجتمعنا المسلم أكيد هو حلل شغلات وحرّم شغلات...

Protesting anal sex, other participants added:

Elsie. To do sex in the natural way

تمارس حياتها الجنسية بالطريقة الطبيعية

Nay. Normal sex ... it has specific areas (not anal sex)... Some areas are prohibited by religion (as Muslim), I mean anal sex.

جنس طبيعي يعني... له محلات معينة، له... وكمان في محل إنو في شغلات إنو الدين بي.. ما ب.. ما بيسمح فيها... إنو يجي امرأة، زلّة من وراء

The meaning women ascribed to sexuality does not correspond to the way they live it. Perceiving sexual life as a marital unifier that guarantees the stability of the family, women do not hesitate to sacrifice, overlooking their own needs and comfort. Once married, they believe that they should be patient and dedicate their life to their family and husband. In other words, family stability is closely associated with the satisfaction of men's sexual needs even at the expense of women's comfort. In this respect, Beatrice, a high school educated affluent housewife said:

Beatrice. It is very important, very important (sex). Pleasure and joy are not necessary; the importance is the bond between man and woman. This thing keeps the family together... Having sex once or twice a week is very important to maintain affection and tenderness even if the woman is exhausted. For me, as much as they have problems... there is nothing that unites man and woman more than love...

For example, last time I was on medications (anxiolytics and antidepressants) that reduce my drive. But, I didn't let this control me. I made the effort for my husband. Should I let him feel that I do not want this (sex) and that I do not feel like it? It's not my fault. I do not want sex at this age especially that I am now 54 years old; it is enough. But the woman should always sacrifice. Even if I am tired, even if I am sick; no [with a strong tone], I should tell him that I am not sick. I should not, it's not right; I did an effort for my husband...

كثير مهم، كثير مهم. لذة، بسط، مش ضروري. المهم هو الوحدة بين الرجال والمرأة. هيدا الشي بيخلي العيله مجموعه ... إن تعمل "سكس" مرة أو مرتين بالجمعة كثير مهم حتى يدم في إلفه وحنان حتى لو المرأة هلكاته. بالنسبة لي أنا قد ما يكون في مشاكل، ما في شي بيجمع امرأة ورجال أكثر من الحب.

أنا مثلاً "أخذت حبوب من فترة، هودي بيخففوا كثير اندفاعي، بس اندفاعي ما خليته يسيطر علي. شديت على حالي كرمال زوجي. إن لازم خليه يحس إن أنا ما بدي هالشي وأنا ما لي جلادة؟ ما خصني، ما بدي ياهم أنا هودي، خلصنا، خصوصاً" إن أنا بعمر هلق 54 ، بعد بدي هلق؟ بزيادة. بس المرأة دايماً "بدها تضحي. لو كنت أنا تعبانه، لو كنت صاخنة، لا. بدي قلّه أنا مش صاخنة، ما لازم، ما بيسوى، أنا عملت مجهود كرماله.

Thus, women who were not attentive to their husband's needs blamed themselves and expressed their fear of losing their personal and family life.

Elsie. Sometimes you are not feeling well or tired; you are not in the mood. But in this case, you are thinking about yourself and not about what your husband wants. You do not know that in this way you are pushing him away from you. It is unacceptable that he becomes sexually and morally distant; he will avoid coming home. When you are so preoccupied with the family, you cannot any longer focus on other issues (sexual relation) and this is wrong.

Reflecting on the woman of the vignette, she said: ... Maybe she is wrong. Maybe she is not able to be everything for her partner; she is not able to respond to his desires. She is wrong. She is not fulfilling her responsibilities ...

أوقات بتكوني مضايقة أو تعبانه ما لك خلق. بس بتكوني عم بتفكري بحالك ما عم بتفكري بجوزك شو بده. ما بتعرفي إك هيك عم بتبعديه عنك. ما بيصير يبعد عنك جنسيا ومعنويا وما بيعود له خلق يجي عالبيت. بينما أنت تكوني ملهية بالعائلة، ما بيعود عندك شي تاني تفكري فيه؟ وهو غلط. ... بركي الغلط منها، بركي هي ما عم تقدر تكون كل شي لشريكها، ما عم تقدر تلبي له رغباته، يعني صار في غلط هيي منها، هيي مقصره....

The reciprocity in the spouses' sexual satisfaction was not evident in the women's discourse. Many reflected on their powerlessness and incapacity to voice their concerns when their husbands were unable to satisfy their sexual needs. Women's attitudes and behaviours are partly justified by the gender-based sexual socialisation and the perception of men's sexuality as physical and theirs as rather psychological. Asma, a highly educated and active woman opined that:

Asma. No, men are very 'physical'. I want to talk about myself. Me as a woman, as far as I'm concerned, this is something more 'spiritual'. There is a lot of affection, tenderness. We have to make sure that these things are always present and to pay attention to them.... However for men, probably it is mostly related to intercourse. Things around them are not that important.

لاء الرجال كثير "فيزيكل". أنا بدي إحكي عن حالي. أنا كمراة، بالنسبة لي، هيدا شي أكثر "سبيريتشوال". في كثير حنان، عاطفة. لازم هودي الأمور نتأكد إنها عطول موجوده وننتبهلن...
بينما للرجالprobably is mostly related to intercourseلي بيصيروا حوليهم
.are not that important

The difference between men's and women's sexuality was further explained by Dima who said:

Dima. The man is always ready, but the woman is not. She should be physically and psychologically ready for it. Men don't care... whereas the woman is very emotional. At the emergence of any conflict between them, she refuses (lovemaking).

الرجال عطول جاهز بس المرأة لاء. لازم جسديا" ونفسيا" تكون جاهزه. الرجال ما بنفارق معه... بينما المرأة كثير عاطفية. يعني عند أي مشكلة بينها وبينه بترفض.

As women believe that men's desires are pressing, they obey their husbands and do their best to satisfy them. For instance, a high school educated housewife whose husband passed away some years ago stated:

Chaten. We obey our husbands. He has the urge to do sex. We rush and pretend that we are so into it. We make belief just to help them, so they are not bothered by us. We went through many such circumstances and we did not let him feel any shortcomings.

نطيع رجالنا. هو مضطر بده يمارس حياته الجنسية، نركض، نعمل حالنا قديشنا منسجمين. نمثل حتى نساعدهم، حتى ما يتضايقوا منا. مررنا بظروف كثير هيك وما خلينا يكون عنده أي نقص.

In support of men's sexual power and leadership and women's submission, Beatrice recounted that:

Beatrice. In our life, it is usually the man who initiates the sexual act with the woman and not the other way round... there is a big difference. It is very difficult for a woman in case she tries to initiate it and arouse her husband and he does not accept?! It is just for his pleasure (she does it), not more than that because man has more pleasure than woman, and he rejects her! So difficult! ... Women have a lot of dignity. Men do not care. He will tell her, if you do not want I can find another woman.

الرجال بحياتنا يعني، دايما " الرجال هو يالي بيتحركش بالمرأة، مش المرأة بتتحركش بالرجال... كثير في فرق؛ كثير صعب للمرأة، أوعا تفكري إذا شي مرة هي تحركشت بالرجال وما قبل؟! إن حتى هو ينبسط بس مش أكثر يعني، لأن الرجال عنده ملذات أكثر من المرأة، وصدها! كيتتر صعبة، المرأة كتير عندها من نفسها. الرجال ما بيهمة ايه بيقولها ما بدك، أنا بشوف غيرك.

Raja explained that it is very challenging for women to express their sexual needs as these are neglected; usually men do. In support of this assumption, women of the FG2 declared having never expressed their sexual needs to their husband. They highlighted several reasons for their behaviour: a) as part of their sexual scripts, they are used to inhibiting their needs and are reluctant to express them; even if they would like to have sex they are afraid of their husband's prejudicial attitude; b) they avoid their husband's embarrassment when he struggles with sexual performance; thus, a fake orgasm is common among women; c) they perceive and engage in sex as part of their duty; and d) they see men as the leader who orchestrates the sexual act. The participants had a discussion that was a kind of support for one another as they share the same sexual concerns. They said:

Razan. Sometimes he is sick or he is tired. I am the type that does not let him feel that (I did not enjoy). I always let him feel that he is top. Sometimes the act does not last 5 minutes, sometimes 15 minutes and sometimes 30 minutes; it depends... I do not let him feel even if I still have the desire... I feel that this is as much as he can give; he cannot last longer... I am with him in everything... but, for example, there is sexual inhibition; but I understand the situation... he asks me if I am ok (if I enjoyed) and I say yes even if I did not feel anything.

أوقات بيمرض أو بيكون تعبان. أنا من النوع يللي ما بحسسو. خلص طول انت top

إيام ما بتدم العلاقة بيني وبينه 5 دقائق، إيام ربع ساعة، إيام نص ساعة. حسب... أنا ما بحسسه إن حتى لو بعد عندي رغبة... أنا بحس إن هلقد قدرته هلقد فيه يطول... انا معه بكل شي. بس إن مثلاً" في كبت جنسي. أنا بتفهم الوضع... بيقللي ماشي الحال؟ بقللو ماشي الحال حتى لو ما حسيت بشي

Sally. This is sexual inhibition

هيدا الكبت الجنسي

Razan. Even if I still have sexual desire I am too shy to tell him that I still have the desire for sex

حتى لو بعد أنا مثلاً" عندي بعد رغبة... ايه بستحي قللو إن بعد والله مثلاً" بعد عندي رغبة لإلك

Sally. In our context, he is the centre of power.

ما هو مركز السلطة. نحننا عنا إن هو مركز السلطة

Racha. In our context, the man is the centre of power.

نحن عنا مركز السلطة هو الرجل

Tressy. It is not the woman who takes the initiative. Me for example, up till now (28 years of marriage), I do not tell him... I do not ask for things (for sex)... To tell him that I am still not satisfied!!!! Wow.

إن مش هي بتاخذ المبادرة. أنا مثلاً" بعدني لهلق مابقللو مثلاً" ... ما بتطلب إشي... حتى قللو أنا بعد ما اكتفيت!!!!؟؟؟ واو.

The participants of the confirmatory focus group highlighted additional reasons for women's suppression of sexual needs including a) their economic dependence; b) the 'Christian holy matrimony' that is hard to break in Lebanon; c) the obedience to Islamic

marital rules; d) the fear of social stigmatisation; and e) the need to let children grow up in a family environment.

On the other hand, some women were proud of dedicating their life to their husband like Karine:

Karine. The most important advice in life is for a woman to take care of her husband first. She should consider him her first priority followed by her children. This is important to keep their marital life in harmony. A woman should be grateful to her husband because he chose her to be his wife... He preferred her to all other women because he loved her... If a person offered you all this... To thank him I should do my best to respond to him sexually.

أهم نصيحة بالحياة هي إن الواحدة تهتم بزوجها أول شيء. تحظ زوجها بالأول قبل كل شيء وبعدان الأولاد بيجوا كرمال يدموا متفقين بالحياة الزوجية لأن الزلمي له فضل كبير على المرأة... بس لما الزلمي إجا وطلبني للزواج، ليش إنت فضلك عن غيرك؟ لأن حبك... إذا هيدا الإنسان أكرمك هالإكرام كله،... جنسيا" لازم كون معه متجاوبة. أنا بحاول كتير أتجاوب معه.

Karine's attitude might partly relate to her religion as a Muslim woman. Abiding by Islam, Muslim participants referred to the Sharia'a law to justify the gender sexual power differential and men's right for polygamy by saying that:

Nay: I try all my best with my husband. A woman should satisfy her husband's needs; otherwise, they have to separate according to our religion, otherwise, she acts against the Sharia'a.

أنا بعمل جهدي مع جوزي. المرأة لازم تأمن حاجات جوزا وإلا بيقتروا نحن بديانتنا وإلا حرام. إذا ما فيها، لازم يتركوا بعضهم.

Hana. We as Muslims, religion urges the woman to put on makeup and propose to her husband. It is her duty to ensure his sexual rights and satisfy him. God gave man more energy; that is why maybe the religion encourages him to marry one, two or three women.

ونحن كإسلام، الدين بيحس المرأة على إن تتبرج وتعرض على زوجها. من واجبات المرأة إن تأمن له حقوقه الجنسية أو تكفيه. يمكن كرمال هيك الدين بيشجع زواج امرأة وتنين وتلاتة لأن الله سبحانه وتعالى عاطيه طاقة أكبر.

Participants' narratives further reinforced the double standard by perceiving women's sexuality illegitimate outside marriage.

Beatrice: 'there is a big difference if she is a girl [not married]... it is very important to be a woman [married] to talk about sexual life...'

في فرق كبير بين إن تكون بنت... كثير مهم إن تكون امرأة حتى تحكي عن الحياة الجنسية...

For instance, the only single participant talked about the social censorship of sexuality that does not allow her to voice her sexual needs. On the contrary, the divorced woman reflected on the sexual assertiveness and maturity that she acquired after her divorce. The three widowers reported on their total sexual abstinence after the death of their husbands to stay faithful to them and avoid social stigmatisation. In this respect, Chaten said:

Chaten. I am not sure what sexual life means to me now because my husband died. I do not want to cheat on him. I am widowed; I do not want to commit a sin. I want to preserve my memories of my husband because he was loyal to me. I do not think about having a new sexual relation with another person.

مني أنا هلق أكيدة شو بتعني لي الحياة الجنسية لأن جوزي متوفي. ما بحب خون. أنا أرملة، ما بدي إخطي. بدي حافظ على ذكرياتي مع جوزي لأن كان وفي معي. ما بقى فكر بعلاقة جنسية جديدة مع شخص تاني.

Middle-age constitutes another additional factor that influences women's perception of their body and sexuality.

5.4.2.3. Middle-age and changing sexuality

The current subtheme comprises women's narratives concerning the perception of sexuality with menopausal changes and ageing. Some women reflected on their positive sexual experience and the maturity that they gained with life experience. They regarded

sexuality as the symbol of youthful femininity that is guaranteed by menses; yet, is threatened by menopause.

Fadwa. A woman is always worried about the cessation of menstruation since her husband will stop loving her. This is because he believes that menses and having sex are closely linked to one another... he thinks that she will no longer be responsive to him. This frightens women.

المرأة بتعطل هم تقطعها لأن بيطل جوزها يحبها. بيفكر إن الميعاد والسكس مربوطين ببعضهم... بيفكر إن ما راح تتجاوب معه. هيدا بيخوف المرأة.

The fear of menopause was mainly expressed by women close to this age period. For instance, Nada (48 years) and Lana (50 years) appeared terrified by the idea of entering menopause. Nada who reflected on her high sexual appetite said:

Nada. I told my husband 'what would happen to me in case my menses cease? Does it affect our relationship? 'Definitely, based on what I hear around me, women become frigid. 'Will this thing happen to me? ... Will it affect me, our relationship? Will I stop wanting this thing (sex)? Will I become frigid? He told me 'no, it does not have any effect.

قلت له لزوجي في حال انقطع ميعادي شو بيصير معي؟ هل هالشي بيأثر على علاقتنا؟ أكيد حسب ما بسمع النسوان شو بيصير معهم، بيصير عندهم برود. هل هالشي سيحصل لي؟ ... هيدا بيأثر علي، على علاقتنا؟ بيصير إن ما بعود بتحمس لهالشي؟ بيصير عندي برودة؟ قال لي لاء ما بتأثر.

As for Lana, she expressed her feelings by stating:

Lana. I am afraid. I am thinking that I have reached this age (50 years), what will happen?... If a woman loves her husband, it is so difficult. Minimum, you feel that you are older. I am seriously thinking about it...; my husband will tell me 'you are menopausal; this is the age of hopelessness'. I will realise that I got older and my husband will look at another woman.

أنا خايفة. عم فكر إن أنا وصلت لهيدا العمر. شو راح بيصير؟... إذا المرأة بتحب زوجها، كتير صعبة. أقل شي بتحسي إنك كبرت. أنا جد عم فكر في. زوجي راح يقللي قصعتك. هيدا سن اليأس. أنا راح انتبه إن كبرت وزوجي راح يتطلع بمرأة ثانية

Asma explained woman's feelings, thoughts, and concerns at middle-age by reporting that as she grows older, her body changes as well as her self-perception. Women go through difficult periods where their moods swing, their needs change and their desires fluctuate. They might suffer physical, emotional and mental distress that make them unsure about their feelings towards themselves and their husbands.

The majority of women announced the decline of sexual interest relating it to hormonal changes and the years of marriage; yet, the perception of sex as incompatible with ageing was commonly reported. For instance, Elise and Jeanne said:

Elise. It is not easy at this age (50 years), it is not easy to talk about your needs. You will be harshly criticised. They will point their finger at you particularly in our area (conservative) [widowed woman].

مش هين بهيدا العمر (50 سنة)، منو هين تحكي عن إنو إنت شو بدك. بيهشموك بلساناتهم. بيدلوا عليك بأصابعهم خاصة "بمجتمعنا (متزمت)

Jeanne. But now (52 years)! Ouf! I have already married off two of my children, my daughter and son. It is a shame to ask for sex. I only do it for my husband. It is a shame, a shame to still think about this thing. It is not any longer for us. It is not worth it any more...

بس هلق (52 سنة)! أوف! صرت مجوزي تنين، إبني وبنتي. عيب نطالب بالسكس. أنا بس بعمل هالشي لزوجي، عيب، عيب فكر بعد بهيدا الشي. ما عاد لنا. ما بقى تحرز...

Perceiving the loss of a powerful characteristic in their spousal life, some women expressed their fear and insecurity as per Odile's declaration: 'what was uniting us died'. Women's fear was exaggerated by the perception of the discrepancy between men's and women's sexuality with ageing. Internalising sexual double standards, many of them limited women's sexuality to the age of 50 and extended that of men to the ages of 60-70. The participants of the FG2 agreed on this assumption supported by Racha's (52 years) experience, who succumbed to her husband's daily sexual appetite despite his 72 years and chronic health problems and medical treatments. Racha was the only participant who clearly announced her vaginal dryness that caused her dyspareunia. But, she tries to

manage the situation by using a lubricant. To remedy the effect of ageing, others opted for plastic surgery of the genital anatomy; yet, Dima's suggestion was:

Dina. When the menopause happens, a man still has a strong need while this is not the case for his wife. Then you are afraid that man will look for other relationships... This is a problem; science should encourage the delay of menopause... As long as a woman is able to fulfil her sexual duties, she will be stronger and her life more successful.

وقت المرأة بتقطعها يكون الرجال بعدها الحاجة عنده قوية. بينما مش نفس الشيء للمرأة. المرأة بتخاف إن يجب عليها... هيدي مشكلة. لازم العلم يشجع على تأخير "المينوبوز"... قد ما المرأة بتقدر تقوم بواجباتها الجنسية قد ما يتكون أقوى، قد ما حياتها بتكون أنجح

Contrary to this view, women of the FGI were cautious of the generalisation as every couple is unique. Reflecting on their experience, Nadege assumed that although sexual activity per se decreases, the quality becomes better. Thus, some women did not complain and others viewed menopause as a way to enjoy sex with no restriction or fear of getting pregnant. After 24 years of marriage, Lea feels that every time she sleeps with her husband it is as if she is having sex for the first time. Elham (40 years), Karine (43 years) and Mirvat (41 years) declared the peak of their sexual desire in their forties. For instance, Elham noted:

Elham. I am now 40. I feel that my body is now nicer than before. Maybe because I became more mature; I am more aware of what I want when I am with a man and how I can enjoy sex. Before, no, you are not like that. Your main concern was to satisfy your husband. You stop caring about yourself. Now, no! You want to satisfy him and yourself as well because you are more aware of what your body needs. At this age, you appreciate your body. You are self-confident and the other has to accept you the way you are; you impose yourself.

أنا هلق 40 وبحس إن هلق جسمي أحلى من قبل. لأن يمكن نضج فكري أكثر صرت أعرف أكثر شو بدني إذا كنت مع شخص وكيف بدني أنبسط. قبل بتكوني لا ، بدك تعرفي ترضي جوزك. ما بيعود يهتمك إنت. هلق لا، بدك ترضيه وترضي نفسك كمان لأن وعيت صرت تعرفي جسمك شو بده. صرت بتعرفي جمال جسمك. هلق إنت واثقة من نفسك كيف ما بتكوني. الآخر بده يتقبلك إنت بتفرضي حالك عليه.

Elham described older couples as 'love birds' perceiving them to have less burdens particularly after the children leave home. Sexual life requires attention and effort from both partners; otherwise, sexual difficulties emerge.

5.5. Women's sexual difficulties

'When it comes to sexual life, the woman is always the victim' (Zeina)

Seventeen out of 52 women reflected on experiences of sexual difficulties which were the result of a complex interplay of physical and psychosocial factors inherent to the relationship. Mediated by patriarchal norms and sociocultural restrictions, women's

sexual difficulties are mainly induced by the mute sexual self. Due to the lack of preparedness, women faced major challenges to cope with sexual life at marriage. In addition, many of them silently bore their husbands' sexual problems, inappropriate behaviour and non-responsive attitude towards their sexual needs. Their sexuality was also affected by the burden of everyday life and stressors.

5.5.1. Sexual unawareness and misconception

Contained within this subtheme is the women's reflection on the difficulties in making the shift from a chaste to a sexual being in view of the lack of preparedness and the misconceptions about sexual life.

Carmen defined women's sexual difficulties as *'their inability to enjoy their body due to their inhibiting feelings when they are with their partners'*. She interpreted these problems in terms of frigidity, vaginismus or inability to recognise their own sexual likes and dislikes as they are not aware of their bodies. She postulated that the *'individuals' readiness to enjoy sex might be countered by a poor language of sexual self resulting into an inappropriate communication and understanding of the partners' one another needs'*. This summarises the problem of vaginismus that Carmen recognised only after two marital years of suffering although she is a psychologist and got married in her late twenties. Carmen underwent seven years of psychotherapy to recover and become comfortable with her sexual life. She noted:

Carmen. Here you have the taboos, I mean the interdictions, the no, the shame, and this is not allowed ... and until now, many women (single young women) do not know why things are not allowed. The shame and interdictions cause sexual frigidity and lead to problems with the husband after marriage because she is not allowed (to be sexually active) before marriage. Suddenly, she gets married and everything becomes allowed.

Psychologically, you are blocked. How she will do it in 24 hours? ... that is why there are a lot of sexual difficulties among women like frigidity and something you call vaginismus; the penis cannot enter; this prevents man to penetrate her; her body is blocked; her body becomes like a stone ...

هون نحن بيجيك "التابو" يعني المحرمات وبتجيك اللاء والعيب وما بيسوى وما بيجوز وبعد لهلق في كثير بنات بعد لهلق ما عرفوا ليش ما بيسى وما بيجوز. فبقى عيب لا ما بيسى وما بيجوز عم بيورط البنت لبرودة جنسية، لمشاكل مع زوجها بعد الزواج لأن ما بيحقلها إن تكون قبل الزواج ما بيحقل ولجسمها يكون قبل الزواج. جسمها ممنوع، ممنوع، ممنوع عليها وإذ فجأة بتتزوج وبصير كل شي حلال.

إنت من الناحية السيكلولوجية سكرتي. طيب بليلة، ب 24 ساعة كيف بدها تفتح؟ يعني هون أنا هيدي ما فيها تفتح، ما فيها تفتح. لهالسبب عنا مشاكل نسوان كثير وبنات كثير بتصاب بالبرودة، "فريجيدتيه" وشي اسمه ال "فاجينيسم" فبتمنع ال "بينيس" يفوت، بتمنع الرجال يفوت لعندها، بيسكر جسمها، جسمها بيصير مثل الحجر.

Faten, another highly educated woman who also was a health worker, faced the same problem although she got married in her thirties. It was after two years of sexual distress that, with her husband's support, she was able to overcome her sexual inhibition induced by guilt and shyness and engage in penetrative sex. Yet, Ibtissam's husband forced himself

on her during their first sexual intercourse while her mother and mother-in-law waited outside to make sure that things had gone successfully and that the bride's virginity was confirmed. Ibtissam remembers this experience with anger; it took her several months to accept her husband and get sexually comfortable with him. She said:

Ibtissam. All what I wanted when I first got married was to dress up, go out and walk hand in hand with my husband ...

Reflecting on her first sexual intercourse she said: *I want to choke him, I do not want, I do not want him, take him, I do not want him, marry him (addressing the talk to her mother and mother-in-law). When I got married I was totally ignorant. I asked him to love me a platonic love. I swore to God, this is what I told him. He told me that 'do you think that I married you just to stare at you like a doll?!' And I suffered; I suffered a lot before I got used to this...*

كيف نحنا أول ما تزوجنا، يلا بس أنا بدي أضهر، بدي إلبس بدي كذا، بدي شنغله لزوجي وإمشي فيه. هيدا بدي إخنقه، ما بدي، ما بدي إياه، خذيه، ما بدي إياه، تزوجوا إنتو"، أعملهم هيك، إن شو هيدا. يعني نحنا أول ما تزوجنا أنا ما كنت أعرف شيء، يعني أنا، أنا أقول له حبني حب أفلاطوني، والله العظيم هيك قلت له! بيقللي أنا أخذتك لحتى إتفرج عليك بس مثل اللعبة يعني؟! وعانيت، عانيت كثير حتى تعودت على هالشي...

Similarly, Kamal's lack of preparedness led to sexual disinterest throughout the long years of her marriage. Her negotiations with her husband to escape this 'tough duty' as she called it, failed. Like Ibtissam, Kamal was another victim of sexual ignorance although she too was a university student at the time of her marriage. She recounted:

Kamal. I am the type who had an upbringing (conservative). When I got married, I told him: I will iron, wash and clean for you, but do not approach me. Imagine the extent to which we were shy and did not have this. Later on, he helped me get used to him progressively. These things (sex) are not important for me. I am not interested in this thing. It does not mean much to me. I do not like (sex). I do it unwillingly. I am not happy with this... is the least of my worries. I don't like it. What is important to me is the way he treats me.

وأنا من النوع إن تربايتنا نحن - أنا بتصور أوا ما تزوجت قتلته: بكويلك، بغسللك، بمسحلك بس صوبي ما تقرب - تصوري قد ما كان عنا خجل وقد ما كان عنا هيدا. بعدان هو صار همهم (لا تقول الاشياء باسميها) لحتى صرت أتعود شوي، ايه، أنا ما بتاثر عندي هالشي. ما بيعنيلي يعني. ما بحب السكس، بعمله بدون ما أنا بدي ياه. أنا مش مبسوفة بهيدا الشي. قرب ما قرب آخر همي. ما بحب. بيهمني أنا معاملته معي.

Many women denied female sexual difficulties and accused men of theirs.

Sara: The woman is stronger than man in sex. A man might develop impotence and need to take medication, fortification and a 1000 other things. But I rarely hear of women taking these things. Maybe her hormones are stronger ... the woman does not have issues with her sexual life unless she is physically ill. A woman is always ready to respond to a man's needs.

المرأة بالسكس بتمها أقوى من الرجال. الرجال بيصير عنده ضعف ويباخذ حبوب ويباخذ مقويات ومية شغلة. بس المرأة قلت ما بسمع إن بتاخذ هالاشيا. الهورمونات عندها يمكن أقوى ... المرأة ما بيصير عندها قصص بالحياة الجنسية إذا منها صحيا" مريضة. المرأة دايمًا جاهزه تتلبي الرجال

5.5.2. Deviation from normative assumptions about sexual behaviour

This section focuses on women's definition of their sexual difficulties as the result of the husband's poor sexual performance with the intercourse –'imperative coitus'– regarded as central to the heterosexual relationship and his unpleasant sexual behaviour.

Ten women reported on their husbands' poor sexual performance accusing them of erectile and ejaculatory problems that they attributed to ageing, diabetes, cardiovascular diseases and stress. One expressed her embarrassment of her husbands' chronic sexually transmitted infections.

Relating sexual difficulties to the age differential, Odile (49 years) reflected on her experience with her husband, (62 years), with resentment:

Odile. When there is a difference in age, man gets his orgasm rapidly and falls asleep. Yet his wife did not come. Fine but what about me? From here on when the problems start; where are my rights? With ageing, the penis becomes shorter and soft. The woman does not feel anymore that there is something inside her. Did you get it?

الرجال لما يكون في فرق عمر بصير يجي ظهورو بسرعة، بتكون هي ما وصلت للذة وهو بس يجي ظهورو بينام. طيب وأنا ؟ من هون بحسّ بتبلّش المشاكل الزوجية أنّو انا وين حقي عندك؟ يبيقصر العضو يعني من بعد ما يفضّي بيبطل في عندو صلابة. بتبطل المرأة تحس أنّو في شي فيا، عرفت كيف.

Women interpreted their husbands' attitude and behaviour as sexual neglect and abuse. Their accounts show ambivalence between their own and husbands' sexual pleasure as explained by Lana:

Lana. Man sleeps with his wife and does nothing. I mean he does it and gets satisfied and that is... You feel that you become used to that... The woman becomes not important; he (her husband) enjoys it and that is. It does not count if the woman enjoys or not. This is also my right, my right. If the situation was reversed, I do not think that he would have been patient... He would have blamed me 20 times. He would have cheated on me or married another woman ... But when the problem is from the man, you have to keep quiet. Frankly, I would have preferred it if he were sick.

But I am not keen (for sex), it is just for him (her husband); so that he does not say that I neglected him... If he likes it, no, I try; I try to do everything (to please him). However, if I want it and he does not, I prefer to think about something else when I sleep. That is what I do. I think of something else. I think that my husband is a good man, my children, thank God, this (sex) is not necessary at the moment... If my husband wants (sex) and I have sexual dysfunction, I treat myself. But if my husband is impotent, why do I have to treat myself?

الرجال بينما مع مرتته وما يعمل شي. يعني هم بينبسط وخلص... بتحسي إن تعودت على هالشي... بتصير المرأة خالص مش مهم، إن هو انبسط خالص، إن هي انبسطت ما انبسطت، مش مهم. حقي هيدا كمان، حقي. لو الموضوع كان مقلوب، ... ما كان طول باله علي، كان لامني 20 مرة. كان حب علي أو تجوز امرأة تانية... بس لما الموضوع من الرجال، بدك تسكتي. بصراحة! بفضل هو يكون مريض.

بس أنا مني مستقتلة. إنو مني ميتة أنا عليها بس كرمالو تما يقول أهملتنى... إذا جوزي بيحب هالشي، لاء
 بحاول. بحاول أعمل كل شي. إذا أنا بحب وجوزي ما بيحب، بفضل فكر بغير شي أنا ونايمة. هيك بعمل. بفكر بغير
 شي، بفكر إن جوزي مليح، ولادي الحمد لله، هيدي مش ضرورية هلق. خلص ... إذا أنا جوزي بده وأنا متضايقه
 (مشاكل جنسية) إيه بروح بتعالج. بس إذا زوجي مش قادر على هالشي لشو بدي اتعالج

Karine, a 43-year-old woman with limited formal education, reported on her husband's sexual problems since the time she got married, 21 years ago. Karine began to discuss her difficulties after she was strongly assured of the confidentiality of the interview. Unable to manage the situation, she preferred to sacrifice for her children. She declared:

Karine. But what can a person do; in our community, once the woman gets married, it is finished. You get married and you get children. You have tried to solve your problems but you failed. What do you do? What is the solution? There are children. You have to sacrifice either your children or yourself. I sacrifice myself.

بس شو بده يعمل الانسان. نحن عنا، نحن، المرأة تزوجت خلص. تزوجت وصار عندك ولاد. حاولت إنك تحلي
 مشاكلك ما قدرت. شو بتعملي، شو الحل يعني. في ولاد. إما بدهم ينظلموا الأولاد إما بدك تنظلمي إنت. أنا بجي
 على نفسي

Mada's case is similar.

Mada ... because he does not answer me, I say that there is no need to talk... There is no need at all; it makes no difference (whether I tell him or not)... I do not confront him... I feel

that he avoids me because he has poor sexual performance... I ask him but he never answers me. This is frustrating... So I avoid talking with him about these issues.

لأن هو ما بيرد، أنا بقول ما في لزوم للحكي. ما في لزوم أبدا، متل بعضها. ما بواجهه... بحس إن بيتحشاني لأن ما عنده قدرة... بسأله بس ولا مرة بيجابوب. هيدا بيقهر. عرفتني كيف؟ لأ، ما بفوت معه بهيك حكيات

Mada's husband being totally unresponsive, she declared not having had sex with him for the past year without any discussion of the topic. Women's powerlessness was amplified by the lack of resources and their dependence on their husbands. During the interview, Mada looked desperate. The need to share her concerns was apparent and her sexual difficulties impacted heavily on her.

Khawla, another participant, cried during the interview because she was severely affected by her husband's sexually transmitted infections that resulted in painful penile-vaginal intercourse. She described her sexual life as disgusting in view of her husband's negligence and abuse of her body. She reported her unwillingness to further respond to his sexual needs. But she seemed to be powerless in view of her precarious socioeconomic status and the fear of getting divorced for the second time and socially stigmatised.

Three participants, Dalia, Zeina and Sara had the courage to report on their husbands' undesirable and painful sexual behaviour particularly the practice of anal sex. As articulated by Sara:

Sara. Sexual difficulties?! Of course I told you when he goes beyond the limits and wants to have anal sex. These problems happen. I do not accept this because I am not an animal to be treated in this way. If he loves me, he has to take care of me so that I to give him this thing from my heart and with love.

المشاكل الجنسية أكيدته قتلته إذا بده يتخطى المرحلة إن بده ينام معي من ورا، هيدي مشاكل بتصير. الواحد ما بيوافق عليها لأن أنا مني حيوانه لحتى إتعامل بهالطريقة. وإذا هو بيحبني وبيخاف علي، بده يداريني حتى أقدر أعطيه هيدا الشي من قلبي ومن محبتي له.

Sara noted that to prevent her husband's embarrassing behaviour, she convinced him that anal sex is unhealthy and might cause him fatal infectious diseases. As for Zeina, she complained of her husband's insistence to always have anal sex as he does not enjoy otherwise by saying: "when it comes to sexual life, woman is always the victim". She declared that:

Zeina. When you are deprived of this need (need for sexual act) that you are used to because of anal sex, you will develop severe health problems. I have psychosomatic problems.

هيدي الحاجة يالي انت إلك فيها (معوذه عليها)، وقت يالي بتمتنعي عنها، ببصير عندك مشاكل صحية كتير كبيرة. أنا عم عاني من أوجاع بكل جسمي وهيدا شي نفساني.

Zeina's tolerance of her husband to save the family and avoid social criticism was in vain since she reported instability in her marital and family life. Being economically

independent, she stopped having sex with him, occupied herself by social activities and visited a professional for psychosocial support.

5.5.3. Quality of the relationship

Common in women's narratives was the perception of sexual difficulties as psychological rather than physical and deeply rooted in the couples' relationship. They asserted that sex does not succeed if it is not driven by emotions and exchange between the partners; feeling uncomfortable inhibits sexual desire and pleasure and engenders sexual difficulties. Talking about her experience, Sawsan explained that sexual life is not only about penile penetration; otherwise, it becomes disgusting. In the same vein, Dalia declared that at the beginning of her marital life, sex was nice and pleasurable. Presently and because of marital conflicts, she completely lost sexual desire and orgasm and sex became a duty. She expressed her exhaustion with her husband accusing him of egoism and total ignorance of her needs.

Dalia. Sexual difficulties happen if the man is self-centred and wants to enjoy himself without caring about his wife... the man does not control himself... the insistence on his wife to always have sex just for himself... it is very important that the woman enjoys; not to be in pain, not be uncomfortable... otherwise, she will completely refuse.

المشكلة الجنسية إذا كان الرجال أناني وبده هو ينبسط وما حس إن مرته انبسطت...والرجال ما يسيطر على حاله... الإصرار على المرأة إن على طول في سكس... كثير مهم المرأة إن تكون مبسوطه ومش موجهه، مش متضايقه... إذا لاء بتعمل رفض كلي.

Because she does not love her husband, Sally claimed her total sexual disinterest; she has sex only as a duty.

Sally. By the way, sorry I do not have any sexual desire. I do it only at his insistence. No way, impossible. I do not have the desire. There is no way that I feel like it. I do not love him.

انا عفكرة يعني "سوري" انا ما عندي جنس الرغبة الا لحتى يعني يصير في عنده اصرار. ولا ممكن، ما بتجي عبالى ولا ممكن تجي عبالى. ما بحبه.

Sally supposed that she would have had sexual desire if she was with another man, implying that sexual difficulties are relational rather than biological. Another example was illustrated by Quinana, a menopausal woman who declared that the main purpose to participate in the study was to talk about her miserable sexual life. She described herself as a sex automat for her husband who she described as rude and abusive. She stated that every time she has sex, she hates herself more and more.

Quinana. My husband's thinking is wrong. He makes me feel that I am only important for this thing (sex). Because of that, I hate sexual life. I need to feel that I am a woman and then take

what you want... I accept everything, poverty, misery, taking care of the house, cooking food every day... but I need him to value my efforts and then you can take from me whatever you want. With a strong tone she said: I give you; you do not take by yourself; I give you.

عقالات جوزي غلط. يعني ما بيحسسنني إن أنا شي إلا بهيدا الوقت. هيدا الشي خلاني أكره العلاقة الجنسية. بدي كون ست بعدان تاخذ يالي بدك ياه. أنا راضية بكل شي، فقر وتعتير وبدبر البيت ويعمل كل يوم أكل، بس بدي تقدرلي ياهن وبعدان تاخذ مني يالي بدك ياه. أنا بعطيك، مش إنت بتاخذ، أنا بعطيك.

I asked Quinana why she was responding to her husband's needs. Her answer was:

I obey him to prevent confrontations and avoid frightening the children... He beats me in front of the children. That is why I try to circumvent things. He mainly boxes me on the head. I stay one week unable to move my head. I am afraid because he harms me. I am afraid for my children... But I often keep silent because of the children. This thing makes me really sad but it is the only thing that my husband wants from me. I have nothing else; I do not have any rights. He does not care about other things. This is the only thing that is important to him. That is why this thing bothers me a lot. I am not happy at all.

I like sex to happen with love. When I first got married, my feelings were different. Now I am so uncomfortable; I feel that this is the only think, 10 to 15 minutes and my duty is over. This is the only thing that a man wants from a woman.

حتى ما يصير مشكل ويخافوا الولاد. بيضربني قدام الولاد. من شان هيك أنا بجرب إن ما نوصل لهون.

مثلاً" بيضربني أكثر شي على راسي بوكسات، بدم جمعة ما في هز راسي. بخاف يضربني لأن بينذيني... بخاف

على ولادي... بس بسكت أوقات كتير كرمال الولاد.

اصطبرت وقالت أنا هيدي الشغلة بتزعني كتير. بحس إن هيدي هي الشغلة الوحيد يالي بدو ياها جوزي. ما لي

غير شي ما لي حقوق، ما بيهتم بغير شغله. هيدي الشغله يالي بتهمه، من شان هيك هيدي الشغله كتير بتزعني.

يعني ما يكون مبسوطه أبدا".

أنا بحب هيدي الشغله تصير بحب. أول ما تزوجت كنت حس غير هلق. هلق كتير بتضايق، بحس إن هيدي هي

الشغله، 10 دقائق، ربع ساعة وخلص وظيفتي... الرجال هيدي هي الشغله الوحيد يالي بده ياها من المرأة.

Quinana expressed her obligation to shoulder this burden alone because she does not have resources or support to envisage a solution to her case. So, she lives at the mercy of her husband. Lacking love and respect, she reflected on her situation with apparent bitterness. Uguette was another victim of her husband's moral, physical and sexual abuse. She courageously voiced her disappointment in front of women in the confirmatory focus group:

Uguette. When you get married, you say that this is the person that I want to live with... get joy with him, and found a nice family... You devote yourself body and soul; then you are confronted by the truth. You discover that you are just here to complete his life, to respond to his needs; to make him happy; but not to be happy as well... your personality dies... you become the outlet for what he wants. You obey him... but you are not (considered) a human being; you cannot express yourself... And if you give up your rights on the first day, your whole life is a loss. The

man you dreamed about disappointed you; you become disgusted with him... if he sleeps with you, you do not want him. You just want him to finish and leave you alone. This means that you are not happy and sexual issues are inhibited... It is very important to feel that you are desired, to feel that you are a woman.

لما بتتزوجي بتقولي هيدا الشخص بدي عيش أنا وياه،... إنيسط معه ونعمل عيلة حلوة... بتقدمي روحك، حالك، بتوصالي للحقيقة. بتطلعي إنت لإكمال حياته، إنت لينيسط هو، مش تتنيسطي إنت... ماتت شخصيتك... إنت صرت المنفذ ليالي هو بده. إنت بتعطيه... بس إنت مش إنسان إنت ما فيك تعبري عن حالك... وإذا إنت تنازلت عن حقوقك من أول يوم، كل حياتك خسارة. الزلمي يالي حلمت فيه خذلك، إنت بتقرفيه... إذا إجا نام معك ما إلك نفس إلا يقوم يخلص ويحل عنك. يعني إنت منك مبسوطه، صارت الإشي الجنسية مكبوبة... كثير مهم تحسي حالك مطلوبه، تحسي حالك أنثى.

Conscious of the violation of her sexual rights, Uguette described herself as a passive recipient who is filled and left like 'garbage'.

Uguette. Sexual difficulties reside in the fact that the woman is a human being just like the man. He wants to reach his orgasm?! And the woman too should reach her orgasm. Otherwise, you are a sexual object for the other to reach his orgasm whereas you, you are an X; you are an X (nothing)... You do not leave me until you get there (orgasm) [strong and anger tone]. But you do not ask if I too reached there?!. This is the sexual problem... He leaves you as if you were an object; manage by yourself; clean yourself; manage by yourself. I got what I want. This is the sexual problem. You might have a sexual disease, you treat yourself. But when your

husband is the problem!!!... When your husband does not offer you money or a comfortable life; I have to work and he doesn't make it any easier. He has nothing material or psychological to offer you, and in addition he maltreats you!!! How is sexual life supposed to be!

المشكلة الجنسية إن المرأة كائن حي مثلها مثل الزلمي. هو بدو يوصل للنشوة الجنسية والمرأة لازم توصل للنشوة الجنسية. وإلا إنت أداة لإنسان التاني بيوصل للذته وإنت "أيكس"، إنت "ايكس"... ما إنت ما عم بتحل عني إلا لما توصل. بس ما عم تسأل هل أنا وصلت؟ هيدي المشكلة الجنسية... بيقوم عنك كأنك إنت سلعة أو شي ويتركك ويمشي دبري حالك، نضفي حالك، إسطفلي بحالك، أنا وصلت ليالي بدي ياه. هيدي المشكلة الجنسية. يمكن إنت يكون عندك مرض جنسي بتتحكمي... بس لمني جوزك بيكون المشكلة! لما جوزك ما بيقدملك المال والحياة المريحة؛ أنا بدي إشتغل وهو ما بيهين حاله. ولا عنده شي مادي ولا معنوي وزياده ما بيعاملك!!! كيف بدها تكون الحياة الجنسية!

Although Uguette was the wage earner of the family, she 'sacrificed' herself for her children and refused to leave the house.

5.5.4. Daily life events and stressors

In this subtheme, sexual difficulties are framed within the context of daily life events and stressors. This includes the different roles women assume as wives, mothers and workers and other personal events.

Life stressors and responsibilities inside and outside the home overwhelm women and limit their sexual interest and pleasure. For instance, Tamara who is the only bread winner of the family explained:

Tamara. If I have poor sexual performance, this does not mean that I do not want (to have sex). The problems of life are enormous and you reach a point where you are tired. You like to do these things but you say that if it happens it happens and if it does not happen, it is ok... Social, financial and family burdens affect it (sexual life) without doubt and cause sexual difficulties. You need suitable conditions to accept the other... I often experience these situations...

إذا كان عندي تقصير جنسي مش معناه ان لأن انا ما بدي. مشاكل الحياة كتيرة وصار بتوصل لدرجة طب ما انت عم تتعبي. انت حابه هول الشغلات تعملين بس بتقولي يلا ان صارت، صارت وما صارت ماشي الحال... ما هي المشاكل الاجتماعية والمادية والعائلية بتسبب عسر من دون شك، بتأثر على هيده (الحياة الجنسية) وبتخلق مشاكل جنسية. بدك ظروف مؤاتية تأمنك تقبل الاخر... أنا كتير بمر بهيدي الحالات...

Reproductive health burdens like delivery, breastfeeding and infertility problems might also cause sexual difficulties. For instance, Mirvat who has been facing infertility problems for seven years said:

Mirvat. The feeling that you have put in the extra effort at the expense of your psychological status to stimulate the desire of your husband who himself might arrive from his work hungry

and not in the mood because the timing is right. This is one of the worst things that might happen in marital life... At this moment, (she stopped talking and then in a hesitant voice said) I feel myself destroyed and often (she cries) I have uncontrollable crying when I finish.

الاحساس انو انت بدك تعملي كل شي اكسترا من اعصابك ومن هيدا لحتى تفريقي رغبة زوجك الي اصلا هو جايي من شغلو يمكن جوعان ومش مفكر بالموضوع بس انت هلق هيدا هو الوقت. هاي الشغلة وحدة من ابشع الاشياء لي ممكن تمرق بالحياة الزوجية... بهيدا الوقت (صمت ثم بنبرة خافتة) أنا بحس حالي مدمرة وغالبا (تبكي) بتنتابني نوبات بكاء بدون توقف بس خلص.

Mirvat's account was quite compelling and made all women in the FGI sympathise with her; they gave her advice to reduce her distress.

Another difficulty was exemplified by Rayan who due to her obesity had low self-esteem, an altered body-image and felt depressed. This affected her sexual desire and led to her incapacity to satisfy her husband's sexual needs. This in turn made her more frustrated. She reported that:

Rayan. I am upset because I feel sad; I cannot wear what I want. I do not like to sleep with my husband a lot. I pretend that I am tired. I am intimidated because of my obesity. This bothers me. I have been in this way for 5 to 6 months. I can't anymore. He used to enjoy it but I didn't. My husband is still young, only 50 years old.

عم بزعل، عندي حزن، ما عم اقدر البس مثل ما بدي. ما عم حب نام مع جوزي كثير. بعمل حجة تعبانة. بدمني
 هيك عم بستحي لأن أنا ناصحة. هالشي عم بيضايقني. صار لي شي 5-6 أشهر هيك. وبطلت وبطلت إن يعني إقدر.
 كان هو ينبسط وأنا لاء. جوزي بعده شاب، عمره بس 50.

5.6. Conclusion

Participants' narratives' suggested that the understanding of sexuality and sexual difficulties resonates within a whole host of meanings that encompass physical psychosocial and cultural elements. Women have been socialised within gender-based norms that overlook their sexuality. All valued sexual life but few showed sexual affirmation and claimed their own sexual desire and pleasure; these are rather their husbands' priorities as their sexuality is biologically driven. Many reflected on frustrating and difficult sexual experiences that are mainly psychosocial and relational. As sexuality and sexual difficulties are multidimensional, so is help-seeking. Women's perception and experience of help-seeking are determined by the interplay of factors that are detailed in the following chapter.

CHAPTER VI. FINDINGS OF THE ANALYSIS IN REGARD TO HELP-SEEKING FOR SEXUAL DIFFICULTIES

6.1. Chapter overview

This chapter reports on the way the middle-aged women of this study address their sexual difficulties and the personal, relational and sociocultural factors that shape help-seeking. It also presents their views concerning the accessibility, availability and quality of sexual healthcare services and quality. It addresses the following two research questions:

- What are the barriers and facilitators that women identify in relation to seeking help for sexual difficulties?
- What are the different sources of help and the preferred characteristics of the helpers that women consider important in managing sexual difficulties?

6.2. Findings

The framework of help-seeking for sexual difficulties is presented in figure IV as a three stage model that comprises the *'Interpretation of the problem'*, the *'Beliefs about help-seeking'* and the *'Sources and quality of help'*.

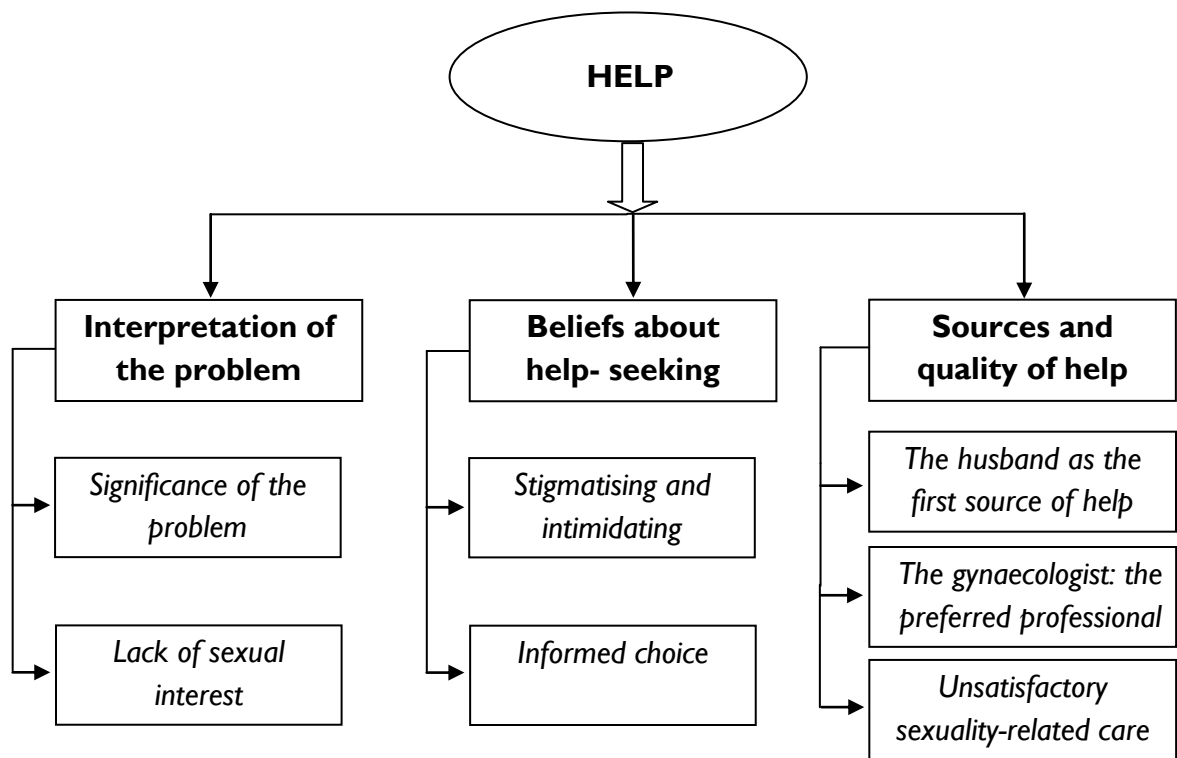


Figure IV. Framework of help-seeking for sexual difficulties

6.2.1. Interpretation of the problem

‘When the problems are stressful, she might talk’ (Hana)

For women in this study, when sexual difficulties were perceived as a serious condition that affected their relationship with their husbands, they showed their willingness to seek professional help. However, women who seemed to be unaware about the nature and severity of these problems or had expressed a lack in sexual interest, help-seeking was

less likely a concern for them. This is illustrated by two subthemes including: '*Significance of the problem*' and '*Lack of sexual interest*'.

6.2.1.1. *Significance of the problem*

Underlying women's excerpts in this section are the opposing perceptions of sexual difficulties, namely whether women consider them as a serious condition or a normal and inevitable aspect of their life. The significance that women attribute to their sexual difficulties affects help-seeking.

The seriousness was illustrated by the perceived severity of sexual difficulties that alters the personal, relational and family welfare. Ibtissam's quote '*some men have their brain there*' (sex is a priority for them) illustrates the intention of women to seek help for sexual difficulties to respond to their husbands' needs as their satisfaction is paramount. This was further explained by Gihane.

Gihane. If she has a sexual problem with her husband that is damaging her life, she is encouraged to talk to find a solution. She should talk...This has a great influence on your life with your husband... When it starts causing problems, she talks... If man does not receive all his rights from her, he either leaves her or cheats on her. I want to talk to avoid pushing him away from me; I want to keep him for me.

إذا عندها مشكلة جنسية مع زوجها عم بتخربلها حياتها، بتتشجع تحكي حتى تلقى حل. لازم تحكي... هيدا كثير
 بياثر على حياتك مع زوجك... وقت بتبلش تعمللها مشاكل بتحكي... إذا الرجال ما بيحصل على كل حقوقه منها، أو
 بيتركها أو بيخونها. بدي إحكي حتى ما بعده عني، بدي ياه يدم لي أنا

Being committed to save the marital relationship for the sake of the family, help-seeking was deemed necessary because '*sexual problems become family problems*' (Gabby). As these problems are the couple's concerns, Dalia opined that both of them should seek help which is less likely to happen. Only Odile did so with her husband.

On the other hand, being unfamiliar with the nature and severity of sexual difficulties, many women attributed sexual difficulties to men and as such did not identify a personal need to seek help. Some of their quotes were '*sexual difficulties usually relate to men*', '*do not happen to women*' and '*women are always ready for sex*'. Elsie explained that:

Elsie. Some women do not know that they have a problem. How can they know?

ما بيعرفوا حالن إن عندن مشكلة، في نسوان ما بتعرف. شو بدو يعرفها.

Elsie found that sexual problems are not physical and thus not easy to detect or predict by examination. Others explained that it is unusual in Lebanon to seek professional advice without perceiving a medical reason. For instance, Dalia consulted the gynaecologist for her own sexual disinterest and absence of pleasure only after one year of suffering. She

was triggered to seek professional assistance only when she realised that the problem might be medical. She believed that what she experienced was normal. She never thought that women's sexual difficulties exist although she is highly educated and described herself as well-informed.

Carmen's thought was that sexual difficulties are highly prevalent but are underreported because of women's ignorance and inhibition. Talking about her case (vaginismus as medically diagnosed), she remembered that:

Carmen. It was ignorance, so I did not know. I was telling myself that this is it (sexual intercourse) and it is as much painful! Maybe it penetrates (penis) this much only. My husband was aware that there was something wrong. He told me that he was feeling that there is some blockage, that I am unwillingly or unconsciously obstructed. You know you say: me! No, there is nothing wrong with us. I did not believe it.

لأن جهل ما كنت أعرف. صرت قول هيدي هي وهلقد بتوجع! بركي هلقد بيفوت. كان جوزي عارف إن في شي مش مضبوط. قال لي إن أنا عم حس إن في تسكير لا إرادي أو لا واعي عندي. وبتعرفي بتقولي إنت! لا ما بنا شي.
ما صدقت

When Carmen was asked why she sought help, her answer was:

I talked because we wanted to find a solution. I did not know that there was vaginismus. We did not know. We did not realise that the problem was as such and that it was a problem for both of us, an inter-couple, or an intercourse problem. I went to the gynaecologist to see what

was there (in the vagina); a cancer?! A fibroid?! A cyst?! There was something. I realised that it was (the problem) in my brain; what I inherited was manifested there.

حكيت لأن بدنا نحللها. ما كنت عارفه إن في "فاجينيس". وما كنا عارفين. ما كانت هلقد كنا عارفين إن كانت مشكلة "أ دو" أو إن مشكلة "كوبل" أو "إنتركوبل" أو "إنتركورس". لا لا إن أنا رايحة لعند الـ "جينيكولوج" حتى شوف شو في هون. في "كنسر"؟ في ليفه؟ في كيس؟ في شي كان. طلع في عقلي، طلع يالي ورتانته واقف تحت.

On the other hand, Nay, a housewife with an intermediate education, did not perceive any severity of sexual difficulties that might require professional assistance or might alter the spouses' life. Nay recounted that in a conservative society like hers, women do not seek help for sexual issues as these are not considered within the medical sphere.

Nay. I do not know that a physician deals with these issues... I do not know any physician, any physician; not at all ... I have only known those I see on the TV... In our context, I do not think that you consult a physician for these issues; I do not think so.

ما بعرف إن الحكيم بيهتم بهيك أمور... إن أنا ما بعرف ولا حكيم، ولا حكيم، أبدا... وما بعرف إلا يلي بيطلعوا على التلفزيون ... عنا ما بعتمد إن تروحي عند حكيم ميشين، ما بعتمد.

The reason for her was that:

Nay. Because they say that it is not a physical problem. They say that it is not a problem by itself. I think that it might not be a problem. The woman can solve it with her husband (talking

about herself). I do not think that a sexual disease causes a problem, I do not think... I wonder, I wonder if women see a physician for such issues.

لأن يقولوا إن هيدا منو، منو مرض عضوي، يقولوا إن منو مرض هيدا بحد ذاته، هلا هو يمكن ما يكون مرض، هي زوجها بقلك وبرجع بقلك بتقدر تحلو، ... ما بتصور إن مرض جنسي بيعمل أزمة، ما بتصور.... ما يعرف، ما يعرف إذا النسوان بيروحوا عند حكيم ليهيك شغلات.

Findings also suggested that women's lack of sexual interest affects their intention to seek help.

6.2.1.2. Lack of sexual interest

In this subtheme, women expressed the lack of sexual interest to seek help as sexuality was not considered a priority or the problem was perceived to be part of the ageing process.

For instance, Odile reported:

Odile. I do not think about this subject. First, I am 48 years old [she laughed], he too (62 years), how do they say we are sated with our life. Medically speaking, nowadays there are surgeries for these issues (reflecting on her husband's erectile problems)... but at this age, I do not believe that we will do this or think about it. The most important is for him to be in good health and for me to be in good health.

ما بفكر بالموضوع. أول شي صار عمري 48 وتضحك وهو كمان كيف يقولوا، شبعنا من حياتنا. طبيا" صار في عمليات... لهالعمر ما بعتقد بنعمل هيك شي أو بنفكر به شي... بيهمني هو يكون صحته مليحه وأنا صحي مليحه.

Other women like Adele and Kamal, two highly educated women who entered the menopause, claimed that sex has never been a priority for them during their whole life and particularly now. Kamal reported relief since the time her husband had open heart surgery and his sexual activity decreased. She claimed that seeking help for sexual problems has never entered her mind. As for Adele, she avowed during the time of the interview being asexual. Although conscious of her lack of sexual desire, she showed a complete unwillingness to address this issue even if her husband should have sexual affairs. She confirmed that she does not want at this age to force herself for any sex whatsoever.

Adele said:

Adele. I am the type who does not like sex much. There are some issues that make me feel happier than sex. Drinking a beer in the nature makes me happier. For instance, I invent something, I paint; I invent things that distract me and are pretty. Art makes me happier than sex. This was especially after menopause. I don't feel like it at all, at all, I do not think about it. Maybe I do not think because my time is full; I am not free. Maybe if I had time for myself, yes I would think about these issues. I do not think; I do not think (about sex). Of course he needs sex and maybe he is going out. But, I am not interested to address this situation... I do not think I will one day see a doctor someday for this... I am not interested, so what for?! (Seeing a doctor)... but when I was younger I was not so interested...

بس أنا نوعي ما بحب السكس كثير. في إشيا بتبسطنس أكثر من السكس. روح إشرّب بيرة وأقعد بالطبيعة
 بيبسطني أكثر. مثلاً "بخترع شي أو بعمل رسم، إخترع إشيا بتسليني وحلوه، الفن بيبسطني أكثر من السكس...
 وخصوصاً" وقت بعد "مينوبوز" ما بيطلع على بالي أبداً "أبداً"، ولا بفكر. يمكن ما بفكر لأن وقتي مليان ومني
 فاضية. يمكن لو فاضية لحالي، إيه بفكر بهالاشيا. ولا بفكر، ولا بفكر. هلق أكيد يعني هو بحاجة يمكن عم يضره.
 بس أنا مش مهتمه حتى عالج الوضع... ما بفتكر راح شوف حكيم شي نهار لهالشي... مش مهتمه، لكن لشو؟! ما
 أنا وأصغر ما كانت كثير تعيلي...

The following section identifies men and women's attitude towards help-seeking as reported by the participants.

6.2.2. Beliefs about help-seeking

'Woman might not go because she is timid; however, man does not go because he is a male'

(Lea)

This theme presents women's narratives concerning their own and husbands' perceptions and attitude about help-seeking that might hinder or facilitate this behaviour. The subthemes about help-seeking are: *'Stigmatising and intimidating'* and *'Informed choice'*.

6.2.2.1. Stigmatising and intimidating

This subtheme stemmed from women's narratives concerning their own and husbands' reluctance to seek help for sexual difficulties. Their attitude was mainly affected by their

own and husbands' timidity and fear of social stigma. Not perceiving a solution for sexual difficulties is another factor that prevents women from seeking help.

As part of their heterosexual relationship, women identified their husbands' resistance to disclose their sexual problems as the main barrier to help-seeking. The commonly mentioned cause was the fear of altering their masculine image. Only one of the husbands that were accused of erectile and ejaculatory problems took the advice of the urologist upon his wife's insistence (Odile). Lana and Sara fortuitously discovered the presence of a medication for erectile dysfunction in their husbands' closets. They inquired about the medication with the pharmacist in the neighbourhood as it was not possible to broach the topic with their husbands since they did not admit their problems. Women's efforts to convince their husbands to seek help seemed to be unfruitful. As a result, these women complained of physical and psychological problems.

Zeina. Do you know how? But I am suffering. I told him man I am suffering with you. It is enough, enough, either you see a physician or you stop it (sexual act). He is now apart (no sexual life). He does not want to be treated and I suffer, I suffer.

عرفت كيف؟ ما إني أنا عم عاني. قلت له يا زلمي عم عاني معك. خلص، خلصنا. يا تحكم يا بلاها. هلق هو صار

قاعد على جنب، ما بده يتحكم وأنا عم عاني، عم عاني

As an alternative, some women consulted a physician on behalf of their husbands, but this was in vain; they did not comply with the medical instructions. For instance, the reluctance of Khawla's husband to apply safer sex practice and comply with the medication she brought him for sexually transmitted infections worsened his case and led to her contracting the infection.

The stigma associated with men's virility if they were labelled with sexual problems affected women's capacity to disclose these problems. This was extensively discussed by Karine before she accepted to participate in the study. She expressed her fear of her husband's reaction if he finds out that she has revealed his sexual problems. Like all Muslim participants, she declared that talk about the topic is in the Sharia' "Haram" (a sin). As noted by Chaten, some Christian women also presented religious excuses to hide their husbands' sexual problems considering sexual life as the sacrament of the Christian marriage.

Chaten. We were brought up based on our religion, the Ten Commandments; we still have shyness. It is not easy to talk about the subject.

نحن ربينا بحسب ديانتنا، الوصايا العشر؛ بعد عنا خجل. مش هين تحكي عن هيدا الموضوع.

Thus, many participants reported ambiguous feelings. They expressed their regret for highlighting very intimate issues of their sexual dissatisfaction; at the same time they

reflected on their contentment as they had the occasion to debrief and voice their concerns.

As such, women's reluctance emerged as another barrier to help-seeking; this behaviour was perceived as unusual for them. As a life coach, Raja reported on the case of many women who usually refer to her for critical situations; they highlight very sensitive issues and avoid talking about their sexual difficulties that often are the main cause of their distress. Raja added that some women stop the sessions when she attempts to bring up the discussion about the subject. Raja's talk was confirmed by the testimony of Kamal attributing her timidity to her conservative upbringing.

Kamal. But I am telling that for a woman, to consult a doctor requires an audacity and an upbringing different from ours. Our upbringing was so inhibiting. I do not talk about these issues with anybody. I am revealing my insights to you; but really, it is the first time in my life that I talk. Maybe if I was not educated, I would have never discussed this issue with you...

بس عم قللك حتى الواحده تستشير حكيم، بدها جرأة، تكون كمان تربيتها غير نحن. نحن تربايتنا كتير كانت كبت أنا هيك إشي ما بحكيها مع حدا. أنا عم طلعك لي بداخلي بس عن جد أنا أول مرة بحياتي بحكي. يمكن لو مش متعلمه يمكن ما باخد ويعطي معك أبدا".

Women's timidity to report their sexual difficulties might be exaggerated at middle-age. For instance, Lana expressed her sexual distress because of her husband's poor sexual

performance and expressed the need for professional assistance. But, being close to menopause she said:

Lana. You are afraid of the society. Now, since nobody knows me, I do not have a problem to talk. But, if somebody knows me, no, I do not talk; Lebanese is a small country (all people know each other)... I prefer to appear happy in my sexual life and not become the talk of the town. Maybe because it is shameful to talk. Maybe because I feel that it is arrogant if a woman talks... At this age, I feel it ridiculous to talk about the topic ... the woman in our culture is shy and this is wrong.

بتخاف من المجتمع. هلق أنا ما دام ما حدا عم يعرفني ما عندي مشكلة إحكي. بس حدا يكون بده يعرفني بحكي... ما بحكي لأن المجتمع اللبناني هون ضيق. بفضل بين ان أنا مبسوطه بحياتي الجنسية أحسن ما كون حديث البلد. يمكن لأن عيب إذا بتحكي. أنا يمكن بحسها وقحنة إذا المرأة حكيت... بحسها سخيقة بعد هلا، بعد هالعمر إني إحكي بهالموضوع. هيدا الغلط إنو المرأة يللي هون بتستحي.

Timidity and fear of social stigma were further depicted by the dialogue of the participants of the FGI.

Mirvat. I see that there is something missing in our culture because the psychiatrist is a taboo; the psychologist is a taboo; what would it be for a sexologist?!

انا بشوف شغلة ناقصة بثقافتنا لأن نحن البسيكياتر عنا عيب، البسيكولوج عنا عيب. فكيف إذا سيكسولوج

Zeina. The woman does not have the courage to go (to a physician)

ما المرأة ما عندها الجرأة حتى تتوجه

Raja. But I also say that this is the religion

بس كمان أنا بقول الدين

Tamara. The timidity does not allow you to go

الحياء يالي ما بيخليك تروحي

Similarly, women of the FG2 conversed:

Razan. The woman needs (to have sex) but she hides this issue because she does not have the courage (to seek help)

المرأة بحاجة بس بتخفي هالشي لأن ما عندها الجرأة

Tressy. I might seek help for my husband more than for myself

ممکن فتنش على مساعدة لزوجي أكثر من لي أنا

Razan. We do not have the courage to seek help

ما عنا الجرأة نفتش على مساعدة

Tressy. A woman does not have a lot of sexual desire

المرأة ما عندها كثير رغبة جنسية

Racha. Because this is a taboo

لأن هيدا عيب

Sally. We are afraid of social stigma; so we do not do it (seek help)

نحن بنخاف من وسمه المجتمع، لهالسبب ما بنعملها

In addition to the aforementioned barriers, some women did not perceive a solution or a priority for their sexual difficulties to seek help in view of the marital conflicts and overwhelming life conditions. Reflecting on their cases, Tressy and Tamara said:

Tressy. If he consults a physician and he prescribes medication for him, it is not wrong if the reason is sexual. But if the reason relates to poverty and worries, the medication can do nothing because the cause is still there.

إذا استشار حكيم ووصفله دوا، مش غلط إذا السبب يعني جنسي. بس إذا السبب من الفقر ومن الهموم بدو يدل عنده هالسبب ما بيعمله شي الدوا

Tamara. ... Definitely you have to tell the physician about all what you have and try to solve the problem. But I do not know to what extent the therapy would be effective. But I tell you again, the psychological status is the most important; the psychological factor is essential.

أكيد بدك تفرغي شو عندك للحكيم وتحاولي تعالجي الأمور. قديش إمكانية العلاج ما بعرف، بس برجع بقلك أنا النفسية هي الأساس، العامل النفسي هو الأساس.

6.2.2.2. Informed choice

In the current subtheme, women suggested that since sexual difficulties are inevitable, they have to develop their self-efficacy and seek help when necessary.

Many participants perceived the normalcy of help-seeking for sexual difficulties as these are similar to any health problem. They related their positive attitude to the familiarity with the health providers to address reproductive health issues and routine screening tests. For instance, Odile did not hesitate to inquire about her sexual functioning for an eventual hysterectomy although she claimed not being any longer interested in sex. Odile confirmed that her sexual awareness gave her self-confidence in discussing all sexual matters and in assisting her husband to solve his perceived erectile problems. In the same vein, Gaby reflected on herself and recounted that:

Gabby. If the woman is educated, knowledgeable and has a good understanding, she definitely seeks help.

إذا كانت متعلمة وبتعرف وفهمانه أكيد بدها تروح.

This was the case of Carmen who sought help to find her identity as a woman and get aware of her sexual being as she felt herself lost and not possessing her body. Carmen's story is unique specifically in the Lebanese context; it would not have happened if her husband and herself were not highly educated, aware about the problem and supportive of one another.

Carmen. When I understood that there is a different story (vaginismus)... there is something different in my body ... I searched for it. I went and dated with other men... I went through all

the steps a woman should have done in the previous years (at an earlier age) ... These things were a bit late with me. But aaah (showing her glory and satisfaction); the best days of my life and I am extremely proud of what I did because I was able to get my life back from them (parents) by myself. I mean I got my life back from them, I got my body back from them because they had possessed it.

وقت يالي فهمت إن في حكاية مختلفه ... في شي مختلف بجسمي، نبشت عليه ورحت وفتشت إن اتعرف على غير رجال ... ومررت بكل المراحل يالي مفروض المرأة تمر فيهم مئ سنين قبل. كانوا مأخرين شوي عندي أنا. بس آآه أحلى أيام حياتي وفخورة بيالي عملته إلى أبعد حدود لأن قدرت استرديت حياتي بأيدي يعني رجعت رديت حياتي منهم، أخذت جسمي منهم لأن كانوا مالكيه.

It is worth noting that few women announced their willingness to seek help for their own sexual pleasure. Raja suggested developing women's self-efficacy as this behaviour is not part of the Lebanese culture. She insisted on the need for women to be aware so that they know what they want and whom to refer to for support. She said: '*I cannot change the world around me but I can work on myself to get what I want*'.

Attempting to get effective assistance, women highlighted the need for access to and availability of reliable resources. Yet, women's narratives indicated that the sources of help are challenging as detailed in the following theme.

6.2.3. Sources and quality of help

'Nobody can understand spouses' concerns more than themselves' (Jana)

Included in this section are women's accounts about the patterns of help-seeking; the quality of sexual healthcare, the availability of and accessibility to services and the sources of help focusing on the role of the husband and gynaecologist. The subthemes are: *'The husband as the first source of help'*, *'The gynaecologist as the preferred professional'* and *'Unsatisfactory sexuality-related care'*.

6.2.3.1. The husband is the first source of help

This subtheme stems from the women's narratives concerning the perception of their husbands as the person most concerned by sexual difficulties. But this does not commonly happen in view of their lack of response to and communication with their wives.

Communication between marital partners in a trustful and comfortable environment was perceived by the participants as rewarding since it strengthens sexual life and satisfaction. Women considered their husbands as the first and most important source of support. They perceived the husbands' role as crucial in the presence of sexual difficulties as these are not only physical. They are conceptualised within the context of the spouses' interactions.

Elham. Talk to your husband and be maximum, maximum transparent. This will solve your problem, not the physician. He is not with you in bed to know exactly what is happening between you and your husband, to understand how you are behaving with each other. As much as you talk, there are a lot of things that remain unrevealed.

احكي أول شي مع زوجك وكوني "ماكسيم"، "ماكسيم" صريحة. هيدا بيحللك مشكلتك مش الحكيم. منه معك بالفرشة حتى يعرف بالظبط شو عم بيصير بينك وبين زوجك، حتى يعرف كيف عم تتصرفوا مع بعض. قد ما تحكي، في كثير إشي بتدم مخبايه

Rayan valued her husband for his understanding and tolerance of her sexual disinterest despite his young age and need for sex. Pamela confirmed that being open to discuss her sexual likes and dislikes with her husband, helped her overcome her sexual disinterest that was associated with family problems. In some cases, the husband's position was strengthened by women's clumsiness requiring his support to cope with the reality shock of sexual life at marriage because of the lack of preparedness. For instance, the support of Carmen's husband was inimitable; he tolerated his wife's extramarital sexual relations as part of her therapy. As Carmen recited, he told her 'go and I am waiting for you whenever you become ready for our life' and he patiently waited for her until she recovered and successfully restarted her marital life with him. Carmen proudly recounted her story and the exceptional approach of her husband. She said: 'our relation does not resemble any other one'.

This approach was not common as many women complained of their husbands' lack of communication in their sexual life and their dominant and non-responsive attitude. Racha's testimony about her husband's very cooperative approach with her to overcome the dyspareunia induced by menopause triggered the other participants of the FG2 to complain about their husbands'.

Racha. It is only the communication (that helps, reflecting on her case with her husband)

ما في غير الحوار

Sally. You need sexual education to let him (the husband) understand these issues and communicate... There should be sexual education

بدك ثقافة جنسية حتى يستوعب هيدي الأشياء ويصير يحاور... بدك يكون في ثقافة جنسية

Razan. You want him to understand this subject

بدك هو يفهم الموضوع هيدي

Sally. My husband does not have a formal education but he is aware of sexual education and he knows everything... But men have something in their mind and do not want to communicate... they are stubborn...

انا زوجي أمي بس يفهم بالثقافة الجنسية وكلو بيعرفو... بس الرجال عندهم شي براسهم وما بدهم يحاوروا...

راسهم عنيد

Razan. Man does not accept to talk about the subject; he is not used to this thing

الرجال ما بيقبل على نفسه إن يحكي بهيدا الموضوع; مش معود على هيدا الشيء

Tressy. What do I tell him? He is like this even if I tell him (he does not change). There is no solution if he is not convinced, there is no solution. We talked a lot about the subject (to be lenient/to communicate). It is a character. This is the way he behaves... This is how we live.

إن شو بدي قلله، هو هيك خلص لو قتلته، ما في حل إذا هو منه مقتنع ما في حل. حكينا كتير بالموضوع. طبع. إن

هيك هو بيتصرف... هيك عايشين

Other informal sources of help were the close relatives and friends whose support was inspired by their sexual experience and perception. Furthermore, perceiving her husband's insistence to have anal sex as a sinful act and a deviation of the stereotypical heterosexuality, Zeina referred to a religious man to get his spiritual support. Her behaviour evoked an animated discussion among the participants of the FGI believing that religious men are in their majority misleading rather than supportive. Thus, many participants preferred to rely directly on professional assistance, primarily the gynaecologist.

6.2.3.2. The gynaecologist is the preferred professional

Women in this study identified the gynaecologist as the most privileged source of help. They reflected on their expectations of him/her while the role of nurses and midwives was controversial.

Many women would rely on the assistance of a professional to address a potential sexual problem believing that he/she is expected to appropriately respond to their needs.

Raja. In my opinion, there should be a specialist. Nowadays, it is neither the mother nor the father. We should refer to these specialists to help us because we will suffer silently and we will transmit this issue to our children.

برأبي لازم يكون في اخصائية. اليوم لا الأم ولا الأب، لازم نلجأ لا هودي الاخصائيين ليساعدونا لأن راح بنعاني
بصمت وراح ننقل هالشئ لاولادنا

Without denying the importance of the role of the psychiatrist/psychologist, women identified the gynaecologist as their preferred source of help. They opted for this professional who provides them with reproductive healthcare and deals with sensitive issues in their life.

Elham. With a gynaecologist, you are not afraid or shy... A lot of them are aware of the woman's needs; the physician becomes your friend, your brother...

مع الحكيم النسائي ما بتفزعي أو بتخجلي... في كثير منهم بيعرفوا حاجات المرأة، الحكيم بيصير صديقك، خيك...

To meet women's expectations and gain their trust, the professionals should be knowledgeable, experts, good listeners and honest.

Faten. He has to know how to let you talk without shyness. For instance, if Sandrine (a public figure sexologist) was in front of me, I would have talked to her because you feel that she is open and you feel that she is experienced. She simplifies things. She lets you feel that there are a hundreds of women other than you who are living the same feelings (concerns).

بده يعرف يخليك تظهري الكلام من تمك من دون ما تكوني مستحيه. يعني مثلاً "لو في ساندرين قبالي كنت بحكيها لأن بتحسيها منفتحته وبتحسي كل الإشياء مارة عليها، بتبسّط الأمور وبتخليك تحسي إن يالي إنت عم بتحسي فيه في مية واحدة عم بتحسه غيرك.

The choice of the professional was also gender-based, reflecting different women's views.

Oumaya. For sure a woman is better... you are more comfortable with a woman as she understands my needs and it is easier to talk to her.

على الأكيد المرأة أحلى... بتكوني مرتاحه أكثر مع مرأة لأن بتفهم حاجاتي وأهون تحكي معها

Hasmig. No I prefer to see a man. No, no he is more competent...

لاء أنا بفضل شوف رجال. هو أشطر...

Both of them, Oumaya and Hasmig, had low education but the former is Muslim and housewife, while the latter is Christian and works outside home.

However, women perceived a limited role for nurses and midwives in sexual healthcare although differing views were observed as per Lea, Carmen and Asma's excerpts.

Lea. I say the nurse, I say that she is half a physician. There are things that they know almost as much as the physician. But you cannot rely on them in everything; you fully trust the physician... I prefer to go to the specialist. I go directly to him; why should I turn around as long as I am able to go to the physician...

أنا بقول الممرضة، بقول عنها نصف حكيم. في إشيأ بيعرفوها تقريبا " مثل الحكيم. بس ما فيك تلجنيلن بكل شي. الحكيم، بتعطي ثقة كاملة... بفضل صاحب الإختصاص. بروح دغري لعنده، ليه حتى نف ودور طالما قدرانه روح لعند حكيم.

Carmen. The nurse really knows a lot; she knows; her field of study is really immense; she knows a lot, she is close to the patients and their families and has more time than the physician and you can ask her... the physician! He barely talks to you. The patients need her support, unless they are not concerned when they are sick. But you see her (nurse), I see her when I am in the hospital for a visit... and she is overwhelmed, she has a lot of work...

الممرضة الحقيقة عندها كتير معلومات، بتعرف، إختصاصها كتير واسع، بتعرف كتير، قريبه للمرضى وعيلن وعندها وقت أكثر من الحكيم. بتقدر تسألها... الحكيم! أنجأ بيحككك. المرضى بحاجه لمساعدتها إلا إذا ما كان بالن هني ومرضى. بس بتشوفها، أنا بتشوفها بس كون بالمستشفى بزيارة... حرام مغلوب على أمرها بالشغل، عندها كتير شغل...

Asma. The midwife has a big and important role... I do not know why this is not strongly apparent... she can have a lot of impact on the couples; she is the most suitable person to deal with issues and problems of menopause. Some of them do; why not?! Sexual issues are very intimate and the midwife is really nice and very understanding...

الساج فام دورها كثير كبير ومهم... ما بعرف ليش مش مبين بشكل قوي... هي عندها تأثير على "الكبس"، هي أظبط حدا حتى يهتم بقصص ومشاكل "المينوبوز". في منهم بيعملوا، ليش لاء؟! المشاكل الجنسية كثير حميمه والساج فام هي حقيقة كثير مليحة ومتفهمه...

Recognising nurses and especially midwives qualifications and their availability and friendly approach, some participants invited them to specialise in sexual healthcare.

6.2.3.3. *Unsatisfactory sexuality-related care*

This sub-theme stemmed from women's narratives about their dissatisfaction with healthcare services as the result of professionals' lack of preparedness and competence to meet their needs. It also reflects on the lack of orientation to know '*where and to whom to go to... for help*' as articulated by one highly educated participant.

Although women's experiences with professionals concerning sexuality-related care were limited, some of them criticised the professionals who did not meet their expectations. For instance, Carmen who was suffering of vaginismus, acknowledged the role of the psychoanalyst in giving her as she said '*the laissez-passer to discover the woman in inside me*'.

However she remembered the bad experience she had with the gynaecologist who was focused on the genital aspect of her problem neglecting its complexity and multidimensional layers. She suggested that the professionals adopt a global approach to sexual problems.

Carmen. My problem was not down. My problem was up.

مشكلتي ما كانت من تحت. مشكلتي كانت من فوق

Lana was also embarrassed of the family physician who advised her to satisfy her sexual needs outside marriage since he did not effectively take in hand her perceived husband's sexual impotence when she referred to him for help. In addition, she accused him of not considering the seriousness of the problem. She criticised his approach because it was limited to the prescription of a drug for erectile dysfunction neglecting couple's therapy and other personal and contextual elements of the problem. Another example was that of Odile who ironically reflected on the physician's way in addressing her husband's problem. She said:

Odile. The physician told him: 'You have to prepare yourself; you have to watch pornographic movies; think about distracting issues'. I interrupted the physician and ironically told my husband: 'think about a sex worker so that things will improve. During that time, he prescribed him a medication but things did not improve.

قللو بذك تحضر حالك. قللو بذك تحضر فلومي، بذك تفكر بغير مواضيع – قتللو، اي جوزي فكرلك بشي وحدة من

تبع السوق حتى يمشي الحال. بوقتنا عطاء دواء ما مشي الحال

When asked if the physician usually discusses with them their sexual concerns during a routine visit, they confirmed that the topic never arose.

Odile. No, not once. Usually this topic, usually the physician (who should ask about it). Even the gynaecologist waits until you ask him to get information. He does not ask.

لاء ولا مرة. عادة هيدا الموضوع عادة الحكيم، حتى الحكيم النسائي بينطرك حتى إنت تساليه حتى تاخدي

معلومات. مش هو بيسالك

In this respect, Asma explained that usually health professionals inquire about flu, fatigue or anything but sexual health. She added that they take these things for granted as if nobody would like to talk about them; this is part of the culture. Carmen explained that the professionals' reluctance to address women's sexual difficulties is attributed to their own context since they are part of the society and were socialised based on the same restrictive norms transmitted to women. She assumed that the professionals might be hesitant to interfere in women's sexual concerns; they might be misunderstood and accused of sexual harassment. Carmen's assumption was reflected by some women's talk:

Kamal. No. Initially this question did not come to my mind. Even if he asks me, I will answer in a restrictive way. I do not like. Then, I say that these are the secrets of one's own home.

لاء. أصلاً " هيدا السؤال ما خاطر على بالي. ولو سألني بجواب بشكل محدود. ما بحب وبعدان بقول إن هيدي أسرار بيته الواحد.

Elsie. No (nobody can ask me), eh, only you. Nobody can interfere in these issues; neither the physician nor anybody else.

لا، إيه بس إنت. ما حدا بيقدر يفوت معي هيك فوتات. ولا حكيم ولا حدا

Highly educated participants acknowledged the importance of including a routine sexual health assessment in the clinical practice as women are often unaware about their sexual concerns or too shy to discuss them. They concluded that the professionals should be well prepared to assume this responsibility. They also suggested the information of women to access the necessary resources asserting their uncertainty about whom to refer to and where to find assistance.

Mirvat. If I face now a sexual problem... or a problem in the relationship with my husband, I, I, I now do not know where to go. I, who was able to assimilate more important and difficult problems (than sexual ones)... I do not know. This is because we do not have this culture.

إذا أنا هلاً بمرء بمشكلة جنسية... أو مشكلة بالتعاطي بالعلاقة مع زوجي، أنا أنا، أنا هلاً ما بعرف لا وين بدي اتوجه. أنا يالي قدرت إستوعب مشاكل أكبر من هيك بكتير وأصعب... أنا ما بعرف. لأن نحن ما في عنا هيدي الثقافة...

Faten added:

Faten. I do not know if there are sexologists in Lebanon; maybe there are not... A lot of women might have problems and do not dare to open their mouths. As I am telling you, they cannot find a person to talk to... If there is a sexologist available for all, this is a very good thing for the person to consult him/her... It is important to consult a sexologist especially for a bride and a groom.

بس ما بعرف إذا في سكسولوج بلبنان. ما في يمكن... ياما في نسوان يمكن عندهم مشاكل وما بيسترجوا يفتحوا تمهم. متل ما عم بقللك ما بيلاقوا شخص يحكوه... إذا في سيكسولوج بتناول الجميع هيدي شغله كتير مليحه حتى الواحد يستشير... مهم الواحد يستشير سكسولوج خاصة إذا عروس وعريس، كتير مهمه.

Reflecting on my experience with these women, many of them were surprised when I informed them about the aim of the study. They were not aware that such a topic could be the concern of a researcher or that a specialty in sexuality may exist. The idea that sexual problems might be serious enough to require professional assistance was new for many of them.

6.3. Conclusion

In brief, findings provided a comprehensive understanding of help-seeking that is shaped by interconnected elements which are the interpretation of the problem, the beliefs about help-seeking and the sources and quality of help. These elements compete together as facilitators and barriers to this behaviour. They are bound to women's personal but mainly relational context showing their readiness to seek help to respond to their husbands' needs rather than theirs as their sexuality is mute. When women perceive sexual difficulties as serious, they assume the inevitable need to refer to a professional for help. However, denying the existence or medical aspect of sexual difficulties and perceiving help-seeking as intimidating and stigmatising, this behaviour is less likely to happen particularly by the husbands. Adding to that, women's decision concerning help-seeking depends on the accessibility, availability and quality of sexuality-related care, knowing that the husband is their first and most important support.

The third and last analysis chapter presents the findings of the two focus group discussions with nurses and midwives about their role in sexuality-related care. This phase of the study was informed by findings generated with the women who in their majority had varying perceptions of the role of nurses and midwives in sexuality-related care. So, it was necessary to explore how these professionals perceive and experience their role in the field as they are in direct contact with women in the hospital and community. As part of their role in the delivery of holistic care, they are well suited to

deal with sensitive issues and explore with women their sexual concerns and difficulties. Even if these issues are not perceived as health problems and do not necessarily require health interventions, nurses' and midwives' roles are not limited to curative care. Their assistance is crucial to provide counselling and helping women understand this period of their lives, be aware about their bodies, know how to anticipate sexual difficulties and how to manage them when they occur.

It would have been plausible to look at the physicians' attitudes and behaviours concerning sexuality-related care. But I preferred to address this topic later on in a separate study and focus in this thesis on nurses' and midwives' roles since women were unaware of their contribution to the field. Thus, I am directly concerned by the promotion of the nursing and midwifery professions in sexuality-related care.

CHAPTER VII. FINDINGS OF THE ANALYSIS IN REGARD TO NURSES' AND MIDWIVES' PERCEPTIONS OF THEIR ROLE IN SEXUALITY-RELATED CARE.

7.1. Chapter overview

This chapter reports on the two focus group discussions with nurses and midwives that constituted the third phase of the study. It is informed by findings of the first and second phase where women had differing views concerning the role of nurses and midwives in providing them with sexuality-related care. While the women agreed on the nurses and midwives' competence in the delivery of healthcare, the majority did not see them as having a substantial role in providing sexuality-related care. It could be assumed that sexuality was not a salient issue in current nursing and midwifery practice. Thus, it was important to explore this further from the perspective of those health professionals, acknowledging the importance of sexuality as an integral part of holistic healthcare and their crucial role in assisting women to identify and deal with their sexual difficulties.

The purpose of the focus group discussions was to answer the two research questions:

- Do nurses and midwives perceive their role in sexuality-related care and if yes, how do they practice this role?
- How are nurses and midwives' roles affected by their personal experiences and the healthcare system?

In this chapter, the term patient refers to both men and women to avoid discrimination. However, nurses and midwives mainly reflected on women as sexuality is difficult to address with a patient of the opposite social gender. In addition, women participants are the focus of this study.

Findings are expected to define the role of nurses and midwives and inform the design and implementation of academic and practice strategies for sexuality-related care which is meant to be part of their responsibilities.

7.2. Description of the sample of nurses and midwives

Two focus groups were conducted with nurses and midwives comprising eleven female professionals (four midwives and seven nurses). Four of them were married. The mean age was 31.6 years with a range of 25 – 43 years. They had an average of nine years of professional experience with a range of 2.5 - 20 years in different healthcare areas in the hospital and community. All of them had at least a Bachelor of Science in Nursing or Midwifery. Four had a Master's degree either in Nursing, Health Management or Psychology; one had a Certificate in Childbirth Preparation and another one a Diploma in Palliative Care. All were engaged in continuous education in different fields of interest. The table of the sociodemographic and professional characteristics was omitted to preserve the confidentiality of the participants. Although pseudonyms were used, it would

have been very easy for nurses and midwives to recognise each other the way they were presented in the table.

7.3. Findings

Data generated with nurses and midwives are presented under five themes: *'Perceptions of sexuality'*, *'Discussing patients' sexuality'*, *'Muting patients' sexuality'*, *'Coping with embarrassment'* and *'Promoting nurses' and midwives' role in sexuality-related care'*. Nurses and midwives of the two focus groups discussed the importance of sexuality in the couples' life and the reciprocity of the sexual relation. Their views about their role in sexuality-related care were controversial in that some of them showed willingness for involvement in the field and others refused to do so assuming that this domain is not within the remit of their practice. Lacking knowledge and skills, many of them reflected on intimidating clinical situations and on the way to cope with their embarrassment. To overcome these gaps and have a more effective role, they discussed many suggestions mainly at the level of nursing and midwifery education.

7.3.1. Perceptions of sexuality

Under this theme, nurses and midwives discussed the importance of sexuality in ensuring women's wellbeing. They also highlighted women's inhibition as a root cause of their sexual difficulties.

At the opening of the discussion, nurses and midwives were asked about their views in regard to sexuality believing that the way they look at the subject affects their practice. Almost all of them seemed to be challenged by the question and did not easily verbalise their thoughts. As a matter of fact, the majority of the midwives and married participants were looking more confident than their other colleagues in initiating the discussion.

Similar to the women who participated in the interviews, nurses and midwives valued sexual life for the individuals' and couples' wellbeing. They described it as a 'boost of energy' and 'mental therapy' that stimulates the person and gives him/her a sense of welfare in relation to the self and the partner. Their common statement was '*good sexual life for a good overall life*' within a relation based on communication and transparency. For example:

Nahla. As a married woman, I will start (reflecting on the participants' hesitance to start the talk). I really feel that sexual relation, a healthy/good relation between a man and woman starts by the sexual interaction and continues throughout other issues. When it is healthy/good, everything is healthy/good. When there is communication, transparency between them, not only their sexual but also their social life improves. They become able to discuss everything. This is very, very important. That is what I think.

انا كمراة مجوزة راح بلس. انا بحس عن جد هلق العلاقة الجنسية، العلاقة بين المرأة والرجال السليمة بتبلس

من العلاقة الجنسية وطالع. ساعة يالي بتكون هي سليمة بكون كل شي سليم. ساعة يالي بكون في communication صراحة بيناتون كمان هيدا الشي بودي ان يصير يعني حياتون مش الجنسية، الاجتماعية كمان بتتحسن. بصيروا يعملوا discussion على كل شي بصير معهن مش بس بهيدي. كتير كتير مهمة. انا هيك بلاقي

While nurses and midwives were vocal in advocating for reciprocity and equality in a couples' relationship, they associated a sexual leadership role to men paralleled with women's poor sexual experience. They interpreted this social reality as part of a whole context of gender discrimination that is a major female concern in the Arab world and a major contributing factor to sexual difficulties. Their assumption was that the majority of women do not orgasm and their difficulties are relational and psychosocial rather than physical. Sabrina, an oncology nurse noted that:

Sabrina. Initially, a study revealed that not only in Lebanon, but 70% of women in the Arab world do not orgasm. The related factors were the background; the upbringing always (the problem).

أصلاً" في study انعملت مش بس بلبنان 70% من النسوان بكل العالم العربي ما بيوصلو للorgasm حتى بهال study يلي قريناها شو طلع القصص background التربية ديما"

Confirming women's claim, the absence of men and women's proper sexual education was identified as another leading cause for sexual difficulties. Based on their clinical practice, the midwives described the cases of many couples who struggle with problems

(not recognising the genital anatomy and how to have penetrative sex; vaginismus; impotence; never experiencing orgasm; and permanent abstinence to avoid pregnancy) because of their misconceptions and lack of knowledge. Zovinar, a community nurse, highlighted the need for sexual awareness by saying:

Zovinar. I think it is a process. I mean women, to arrive to this age group, the problem relates to the absence of a proper sexual education. If you are prepared for sexual changes and for every phase (little girl, teenager, adulthood, menopause), you would have a more appropriate response.

انا بعنقد ان *it's a process* يعني ال *women* تتوصل لهدا العمر يالي عم نحكي فيه *the problem* عنا ان *we don't* have a proper sexual education...

انا بعنقد ان إذا محاضرة للتغيرات الجنسية وكل مرحلة (little girl, teenager, adulthood, menopause), you would have a more appropriate response

Nurses and midwives agreed that sexual difficulties are highly prevalent but are underreported. Thus, many of them identified the need to break the taboo around sexuality; others contested the field. How the role of nurses and midwives is conceptualised and affected is presented below.

7.3.2. Discussing women's sexuality

This theme illustrates nurses' and midwives' perceptions concerning the delivery of sexuality-related care and the need to integrate this role in their daily practice. The majority acknowledged the importance of the discussion of the patients' sexual concerns as many diseases and therapies affect sexuality and make the patients worried and in need of information and support. A relationship based on attentive listening, time commitment and dedication in a private, trustful and non-judgmental environment was deemed warranted to respond to patients' sexual needs.

Rea. Because someone came, broke the ice with the patient and triggered the patient to talk... you initiated the conversation... you gave the patient the opportunity to talk...

لأن في حدا إجا وكسر الجليد مع المريض وحمسوا يحكي... إنت بلشت بالحديث... عطيت المريض الفرصة حتى يحكي...

Nahla. Initially this discussion could not be broached unless you trust the person in front of you and you are sure that this person will listen to you and keep your discussion confidential.

بالأساس، هيدا الحديث ما بينفتح إلا إذا بتوثقي بالشخص يالي قبالك وأكيده إن راح تسمعك وتخلي حديثك سر

The majority of participants especially those who were engaged in community health (Nahla, Dzovinar, Jennifer), had long years of experience (Adrea) and were assigned staff development responsibilities (Rea), defended their position as caregivers, educators, and

advocates for their patients. They expressed their willingness to have a fundamental role in sexual healthcare. Rea suggested the incorporation of sexual assessment in the physical exam as she is a specialist in the domain. Assertiveness and maturity were identified by Dzovinar as fundamental for an effective role. Adrea described a distinguished nurse or midwife as the one who goes beyond the routine care to discover the latent issues, catch the cues articulated by women and trigger them to talk. Reflecting on her practice, she said:

Adrea. Every day during my morning rounds I interview every patient and ask him/her about his/her concerns, otherwise, the patient does not talk...

She tells the patient: Bring a paper and write down all your questions... ask and do not be shy... ask all that comes to your mind...

*كل يوم على morning round بسأل كل مريض عن الأشياء يالي عم بتشغلله راسه، غير هيك المريض ما بيحكي...
تقول للمريض: جيب ورقة واكتب عليها كل السؤالات طبعك... اسال وإياك تخجل... اسأل كل شي بيخطر ببالك...*

Adrea's enthusiasm and self-confidence in discussing her daily practice granted her power within the members of the group. She represented the model of a good and determined nurse leader particularly for the novice professionals.

Based on her long years of experience as a midwife in the hospital and community, Jennifer confidently asserted the positive impact of a feminine and trustful approach on

women's disclosure. The majority agreed and valued sexual assessment as a first step to appropriately address women's sexual concerns through interdisciplinary teamwork.

Jennifer. We will not solve all the problems of women, I am sure. But at least, we, in our way as women, we can let women talk to help them and address their needs as appropriate. We have a referral role and we have to work as a team to solve women's problems.

نحن ما راح نحل كل المشاكل، أنا أكيدة. بس بالقليله نحن بطريقتنا كنسوان، بنقدر نخليها تحكي حتى نساعدنا بشكل مناسب. نحن بنقر نحولها ولازم نشغل كفريق حتى نساعد النسوان يحلوا مشاكلهم.

Other nurses and midwives had opposing views and negative attitudes, thus further muting patients' sexuality.

7.3.3. Muting women's sexuality

Nurses and midwives identified many factors that adversely affect the discussion of patients' sexuality. These were attributed to the lack of self-confidence as the topic is taboo and socially stigmatised, not perceiving sexuality as a priority for the ill patient, being overloaded and lacking privacy and power within the current healthcare system.

The participants admitted that sexuality is not part of nursing and midwifery culture, criticising the curricula that merely address the subject.

Rayan. We learned in our upbringing that the topic is intimate. That is why we have not yet reached the point where we are able to approach it easily or consider it as a concern like other topics.

تربينا ان هيدا الشي intime

من شأن هيك بعد ما قدرنا نوصل لمرحلة ان يكون لنا سهل، او يكون عنا إهتمام تجاهه مثل غير مواضيع.

Jennifer. It is a taboo topic. It is seriously a taboo for us also. We, how we were brought up? We were inhibited before we entered universities and learned. We took 15 hours of sexology; nurses take less. Are 15 hours enough?! Not at all. How much we liked these 15 hours so that we can learn more because we do not talk about the topic within our family...

c'est un tabou, c'est un sujet tabou ان عن جد لنا كمان. نحن تربينا كيف؟ نحن تربينا عالكتب قبل ما

نفوت

Un cours de sexologie 15 heures et les infirmières en prennent moins. Est-ce que les 15 heures sont suffisantes ?! pas du tout. جامعات ونتعلم. نحن أخذنا

قدش كنا نحب هال 15 ساعة حتى نتعلم أكثر لأن ما بنحكي بهيدا الموضوع dans notre famille

Some nurses and midwives stated that it is up to the patients to broach the discussion if they have a problem; otherwise, it is an intrusion in their private life. The unwillingness to get involved in this professional role was mainly apparent among oncology and psychiatric nurses. They were astonished of the idea of addressing the subject matter.

Sabrina. Frankly, in the oncology unit where the majority of the patients are moving towards death, this subject is not very important anymore.

Oncologie كطابق يالي اكتريتهن رايعين للموت، بكل صراحة هيدا الموضوع ما بقنى كثير مهم

Angy, another oncology nurse, did not perceive women who had undergone mastectomy to be ready to discuss any sexual concerns, although she seemed sure that their body image and femininity were deeply affected by the surgery and this would probably affect their sexuality. As for Damy, a psychiatric nurse, she declared her total disinterest; she said:

Damy. I do not feel that my role in sexual health is as important as my role in the medication, observation, high blood pressure ... I do not care if the patient's sexual needs are fulfilled when there are other more pressing issues... Frankly I do not care even if I might be a bit rude...

ما عم حس ان هلقدم مهم ان انا اقدر كون لي دور فيه متل ما انا لي دور إن أعطي الدواء، راقبه، ضغطه عالي، في إحباط... Je m'enfous; I do not care إذا حاجاته الجنسية مؤمنه بينما في أولويات تانية... بصراحة

Je m'enfous حتى لو بدى كون شواي جفصة

Damy expressed her opinion with determination presuming that sexuality of psychiatric patients is not addressed on the floor. Adrea, another nurse in the medical-surgical floor, had an opposite view. She contested the participants who were against sexual healthcare

by telling the story of a dying woman who expressed her sexual worries to her. She narrated:

Woman: Do you think that he (her husband) still looks at me like before?

Adrea: Sure he does. He does not leave you alone even for a minute. What do you feel?

Woman: I do not know. I feel that man's interest is in his belly and what is just below his belly.

Adrea: Maybe, but what do you feel?

Adrea said that she started crying.

Woman: Do you think that he goes out?

Adrea in addressing her talk to the members of the group: Did you see what her worries are?

But she was dying. She was crying because she was unable to respond to her husband's needs.

المرأة: شو قولك بعدو هيك بيطلع فيي متل قبل؟

أدريا: اكيد ما ببتركك ولا تكة. ليه شو عم بتحسي؟

المرأة: شو بيعرفني، بحس الرجال باله ببطنه ويالي تحت بطنه

أدريا: ممكن بس انت شو عم بتحسي؟

أدريا قالت أنها بدأت تبكي

المرأة: شو قولك عم يضر علي؟

أدريا: شفت مخاوفها وين؟ عم بتموت. صارت تبكي لان هي ما عم تقدر تلبيه وبتحبه كتير

The stigma associated with sexuality-related care was evoked by the participants as an additional factor that increased their reluctance to address the patients' sexual issues. Sexual therapy was perceived as a threat and a source of criticism of women by the partner and the society.

Rea. The therapy of the couple is problematic more than sexuality by itself... When I read "Cosmopolitan", "Mondanité", all people share their concerns with the sexologist because it is anonymous... It is easier much easier for the woman to discuss these issues behind a screen rather than with her partner even...

La thérapie du couple هو problématique أكثر من ما هي la sexualité... cosmopolitan', 'mondanité', tout le monde partage avec la sexologue car c'est anonyme... C'est beaucoup plus facile pour elle d'en discuter derrière l'écran qu'avec son partenaire même...

Comparing the stigma related to sexual and mental health problems, Damy stated:

Damy. The way we learned about sexuality is a major problem. A psychiatric patient is similar to having a sexual problem. What a problem! What a catastrophe! (to have a psychiatric or sexual problem)

طريقة يالي نحن تعلمنا ال sexualité هي مشكلة مهمة يعني ال sexualité تمثل هلق بتقولي
مريض psychiatric ذات الشي اذا عندو sexual problems. شو هالمشكلة وشو هالمصيبة.

Thus, nurses and midwives made the nuances between sexuality as a taboo and sexuality as too private and intimate to discuss openly for fear of social judgment. This seemed to be particularly complex for the professionals who practice in the hospital where they faced many challenges inherent to the healthcare practice. They stressed the influence of: a) the workload that does not allow them to give priority to sexuality in regard to other pressing issues; b) the patients' short stay in the hospital that is not suitable to forge a trustful relation for sexual discussion; c) the healthcare system where every woman refers to her physician, usually the gynaecologist, to address such a sensitive subject; and d) the lack of privacy for women hospitalised in two-bed rooms. Nurses and midwives also reflected on their lack of power within a private healthcare system dominated by physicians. This was assumed to affect their social image that is not well recognised and properly valued, whereas the physician is seen as more knowledgeable, competent and trustworthy.

In comparison to their practice in the hospital, the participants identified an expanding nursing and midwifery role in the community where they have more potential and authority to act in a systematic, holistic and contextual approach with women.

Sabrine. This is the idea; in the community, the nurse has the right to do these things. These are part of her work... She can work in a systematic way with every family.

ما هيدي الفكرة ان هي *elle a le droit* يعني انت مجرد ما تقولي ان هي *Nurse dans la*

communauté

يعني هي شغلتها هيدول القصص. اكيد هي بتقدر تشتغل بطريقة *systematique* مع كل عيله

Zovinar and Nahla reflected on their active and independent role in the community that allowed them to prove themselves. As they claimed, women's trust gave them credibility, self-confidence, and willingness to further meet their expectations.

Zovinar. The fact that you are a nurse, women know that you are always ready to listen to them. They are comfortable with you. If they trust someone they go to the extreme.

The fact that you are a nurse, if النسوان بيعرفوا ان انت دايمًا "مستعدة تسمعيهن. خاصة" بيرتاحوا

معك

they trust someone they go to the extreme

Nurses' and midwives' embarrassment of sexuality-related care was counteracted by the use of different coping strategies.

7.3.4. Coping with embarrassment

The current theme stemmed from the participants' embarrassment inherent to the care related to patients' sexuality and the use of delegation, avoidance and humour as different alternatives to cope with the situation.

In an attempt to escape their embarrassment, many nurses delegated sexuality-related care to the midwives believing that it is the core of their profession or else to the physician. However, the midwives often rely on the gynaecologist to take charge of this responsibility as their work is mainly focused on the reproductive health priorities. Unexpectedly, three out of eleven participants asserted that they cannot identify with sexuality-related care and refused to recognise this role as part of their scope of practice. For instance, Sabrina's seemingly rigid position stimulated a debate among nurses and midwives of the group.

Sabrina: I am against the nurse who takes this role

أنا ضد الممرضة تأخذ هيدا الدور

Noel: I do not agree with you

لا انا مني معك

Rea: Your role is not limited to only support; it is wider than that

Your role is not limited to only support. هو أكبر من هيك

Sabrina: You do not have the right to give your opinion

انتعطي رأيك *tun'as pas le droit*

Melissa: You have to have years of experience; not someone newly graduated

لازم يكون عندك سنوات الخبرة، مش واحدة جديد

Sabrina: How many of us are prepared for sexual healthcare?

كم حدا منا مؤهل يعطي العناية بالصحة الجنسية؟

Rea: It is a justification of the lack of knowledge. Do training and in this way you will know...

اعملي training بتصيري تعرفي. C'es une justification pour le manque de connaissances

Noel: Why the physician should have a role and we should not?

ليش الحكيم بده يكون عنده دور ونحن لاء؟

Sabrine: But the nurse does not have the right to give her opinion concerning this topic

بس الممرضة ما لها حق تعطي رأيها بهذا الموضوع

Holding an MA in psychology increased Sabrine's conviction of nurses' lack of preparation to address patients' sexual concerns. She believed that sexuality-related care is too complex and requires a lot of education and training. The other members of the group admitted their limitations, but contested Sabrine on the point that they cannot deny their role in the field and totally delegate it to other professionals. It is worth mentioning that at the end of the focus group discussion, Sabrine seemed to have a more flexible opinion.

Avoidance was another tactic adopted by the participants to escape to their timidity and social stigma as recounted by Rayan and Noel although both of them are midwives.

Rayan: For my part, I am shy. If I will ask her, she will notice my perplexity. For us also the subject is taboo.

بستحي. ان ما راح إجي إسأل مريضة إن . انا اذا بسألها بيبين علي اول شي إني ملبكه. لنا كمان يعني

C'est un sujet tabou

Noel. You know that even as a midwife, you cannot sometimes talk; they think that you are sexually experienced and this is socially unacceptable as a single woman.

Même en tant que sage-femme أوقات ما فيك تحكي، بيفكروا إن عندك خبرة وهيدا مش مقبول اجتماعيا " كمرأة
عزبا

Humour was identified as another way to cope with intimidation. For instance, Damy described her embarrassment when a man complained to her about the sexual hyperactivity of his bipolar wife. To escape this extremely intimidating situation, she made a joke about the husband's talk and left the room.

Damy. One day I was taking the family history with the husband of a woman who had severe mania. What is the problem? He answered 'She does not leave me' (her excessive need for sex). Me!!! (She was so surprised) Mr! Sorry Mr.

Every second, every second (continued the husband). Here, for sure I became totally red... I told him 'you are abused?' I did it just to reduce my embarrassment... then I changed the conversation and avoided more details about the subject with him because I was so shy. I made fun of it and left the interview room. But during that time, you cannot imagine how much he was embarrassed and I was intimidated!

Manie très sévère عندا *histoire de la femme elle était* كان في مرة زلمة، عم ناخذ ال

شو المشكلة؟ قال ما عم بتقوم Monsieur! sorry monsieur كل تكة وتاني، كل تكة وتاني. انا هون

عني. انا!!!

اكيد احمریت... قلتله انا عم تتعنّف؟ بدي اكسر شوای... ايه وبعدين فتت بقصص تانية، سكتت، ما عدت فتت

بـdetail لان انا اكيد استحييت، أخذتها بمزحه، ورجعت رحت. تركت غرفة الفحص. بس وقتها ما بتتخلي

وضعه قدي هو مزعوج وأنا محرجه.

To justify her behaviour, Damy reflected on her timidity with her husband where she never approaches him if he does not take the initiative. She was innocently laughing while reflecting on her story asserting that she is copying her parents' life and is unable to change.

7.3.5. Promoting nurses' and midwives' role in sexuality-related care

Talking about the general context of nursing and midwifery practice, the majority of the participants acknowledged the neglect of this aspect of their practice. Conscious of this professional deficiency, they discussed many strategies to promote their role. Their main suggestions were:

- Overcome the timidity and taboo around sexuality by providing sexual education at an early age.
- Have a solid professional preparation to attend to the emerging sexual healthcare needs.

- Encourage the specialisation in the field of sexology as a way to deliver more efficient care.
- Give attention to sexual health assessment as part of nursing and midwifery patient history.
- Advise the collaboration of the different professionals in the field of sexuality through an interdisciplinary teamwork.
- Develop counselling centres to encourage women to consult and seek help.
- Raise public awareness about sexuality and sexual difficulties.
- Empower women to raise their sexual concerns.

Examples of nurses' and midwives' narratives are:

Nahal. Sexual education should start at school like what Jennifer said. The mother, daughter and son; I mean since the early age...

بدا تبلش من المدرسة مثل ما قالت جيسي من نحن وزغار *éducation* الام والبنت والصبي،... يعني نحن وزغار

Jennifer. They can do awareness campaigns' for the parents to prepare them.

فيهن يعملوا دورات للاهل، تهيأوهم

Rea. Very important to target women... support them... inform them...

كثير مهم تتوجه للنسوان... تساعدن... تفهمهن...

Angy. I think that the specialty is very important. It is true that a multidisciplinary team is very important, but if not prepared? I prefer to have one competent person who can deal with these

things with the patient rather than having 100 persons with different opinions... there should be someone knowledgeable who likes to discuss these things... If you do not like the field, you cannot do it...

انا بحس ان formation ال كثير مهمة. صح ال

équipe كثير مهم بس اذا ما

multidisciplinaire محضر؟

بفضل إن يكون في شخص واحد يقدر هو يشتغل مع المريض عهالاشيا، ولا إن يكون في 100 واحد، كل واحد

يعطي جواب... بيكون في حدا بي فهم وبيحب هيدا الشئ يحكي فيه... إذا ما بتحب هيدا الموضوع ما فيك تشتغل

فيه...

7.4. Conclusion

Findings of the two focus groups answered the research questions and provided insights into nurses' and midwives' perception and practice of their role in sexuality-related care. The discussion was an opportunity to reflect upon their practice and identify many personal and contextual factors that prevent them from having a proper role in this domain. The majority acknowledged the importance of sexuality and the need to consider it in their daily practice. However, they all complained of their lack of knowledge and expertise and had suggestions to conquer negative attitudes, social stigma and barriers related to the healthcare practice.

CHAPTER VIII. DISCUSSION OF FINDINGS OF THE ANALYSIS IN REGARDS TO WOMEN'S UNDERSTANDINGS OF SEXUALITY AND SEXUAL DIFFICULTIES

8.1. Chapter overview

The discussion of findings is split into two chapters. The current chapter starts with an introduction that provides a brief overview of the overall findings as guided by the research questions of the study. It then discusses the key findings on women's understandings of sexuality and sexual difficulties and interprets their meaning as socially constructed realities and in reference to the general literature.

8.2. Introduction

A cross sectional exploratory multiphase qualitative study was conducted to understand the meaning middle-aged women of 40-55 years attribute to sexuality and to examine their views and experiences of sexual difficulties and help-seeking. In addition, the nurses and midwives' role in sexuality-related care was explored. The study was underpinned by a social constructionist framework with a 'twist of pragmatism' using an interpretive methodology. Believing in the subjective multidimensional nature of sexuality and contesting the medicalised conceptualisation of sexual difficulties, this theoretical frame was the most suitable choice for the study. In addition, a twist of pragmatism was appealing to provide flexibility in the way the researched topic was addressed and findings

valued based on their positive consequences within the Lebanese context where sexuality is mute and sexual research timidly addressed.

Women used the language to construct a comprehensive meaning of their sexuality encompassing their sexual problems and the way they manage them. In congruence with social constructionism, the language is central to the social origin of meaning making. It contributed to the understanding of women's sexual thoughts, attitudes and experiences as the result of social interactions and processes. However, the notion that verbal expression could perfectly transmit the reality is idiotic. Thus, to consider that women's sexuality is only discursively constructed means that sex is meaningless outside sexual discourse. Foucault (1987) postulates that the understanding of sexuality should focus on what is said but also what is not said particularly that the topic is veiled in shame and lack of knowledge. This probably affects the way women of this study reflected on their sexuality. Many of them were comfortable in expressing themselves and others were somehow timid and careful in choosing their words or disclosing their sexual issues. Their discussion was rather focused on their husbands' sexual needs and problems within a discourse of heterosexuality and heteronormativity.

Being aware of the medical, political, historical and social powers that shape the meaning making of sexuality, the use of language in a certain context and time is a necessity; it is likely to involve particular ways of understanding sexuality that is communicated by

particular linguistic conventions and classifications. Thus, the middle-aged Lebanese women created a comprehensive meaning of their sexuality using their own sexual discourse. Guided by the social constructionist view, data generation and analysis were conducted in a way that allows the emergence of different meanings of sexuality. A comfortable, confidential and understanding relationship was created with women accounting for their physical, relational and psychosocial backgrounds. They were given the opportunity to maximum talk about their differing sexual views and experiences using their own words. My interference was maintained to the minimum avoiding leading or charging questions that would negatively influence women's perception of their sexuality. The analysis and interpretation focused on the discursive construction of sexuality as cultural and social embedded while controlling as a researcher my personal subjectivity and potential biases.

The study was focused on the following research questions:

1. How do middle-aged women perceive and make sense of sexuality?
2. What informs women's sexual views and experiences and how does the construction of sexuality vary in relation to their menopausal status, level of education, religion and occupation?
3. How do women describe their sexual difficulties and what are the factors that affect their sexual activities and interactions?

4. What are the barriers and facilitators that women identify in relation to seeking help for sexual difficulties?
5. What are the different sources of help and the preferred characteristics of the helpers that women consider important in managing sexual difficulties?
6. Do nurses and midwives perceive that they have a role in sexuality-related care and how do they practice this role?
7. How are nurses and midwives' roles affected by their personal experiences and the healthcare system?

The answers to the research questions are articulated around a set of different themes and subthemes that emerged from the findings and made a unique contribution to the understanding of the under studied subject, particularly within the Lebanese context.

The meanings women attribute to sexuality resonate within a mute sexual self although they perceive sexuality as an important component of their individual wellbeing. Women's sexuality is affected by a sexual socialisation characterised by messages of modesty and compliance to restrictive social norms, poor sexual information and silent sexual discourse that was perpetuated from one generation to the other. Women's mute sexual self resulted in frustrating sexual experiences at marriage, supposedly corresponding to the first heterosexual activity. Women value their sexuality through a sacrificing role where their husbands' satisfaction is paramount to maintain the cohesion of the family.

Thus, sexuality is a means for a 'sublime' end rather than a source of personal pleasure. Many women were challenged by the perception of menopause as a threat to their femininity and sexuality while some others gained sexual maturity and affirmation with ageing.

Women's sexual difficulties are multidimensional. They are deeply affected by invalidating sexual socialisation and patriarchal norms leading to poor sexual literacy. The husbands' undesirable sexual behaviours and denial of their sexual problems in addition to the marital conflicts and burden of daily life are other major factors of sexual difficulties. Findings challenge the medicalised conceptualisation of women's sexual difficulties labelling them as sexual dysfunction.

The facilitators and barriers women identify as related to help-seeking for sexual difficulties resound with the multidimensional aspect of these difficulties. Help-seeking is triggered by the perception of the seriousness of sexual problems and the normalcy of this behaviour. The identified barriers are the lack of sexual interest, the no perception of sexual problems as female-related or physical and the stigma and intimidation around help-seeking from the part of women and their husbands. The husband is their most important source of help while the gynaecologist is their preferred professional. Sexual disclosure is affected by the attitude of the helper and the quality of the support provided. The role of nurses and midwives in sexuality-related care is not well recognised; yet, these

professionals' assistance is critical for women in view of the sensitivity of the subject and their direct contact with them.

Exploring the subject with them, nurses and midwives acknowledge the importance of sexual life, the egalitarian and mutual sexual interaction between men and women and the advocacy for women's sexual rights. Some nurses and midwives were with the integration of sexuality-related care in their daily practice and others were against this role mainly because of their lack of knowledge and skills in the field and the no perceiving of the ill patients' sexual needs. They adopt different strategies to escape this role and the patients' inquiries about sexual issues. However and regardless of their views and attitudes, all nurses and midwives agree on the need to update the nursing and midwifery curricula in line of the emerging needs in sexuality-related care to have a more effective contribution in promoting women's sexual wellbeing.

These findings are discussed in light of the literature, guided by the research questions and the different themes and subthemes.

8.3. Meaning of sexuality

In this part of the chapter, two research questions are discussed, providing an understanding of the meaning of sexuality for women and the way they are shaped by a sexual socialisation. These research questions are:

1. How do middle-aged women perceive and make sense of sexuality?
2. What informs women's sexual views and experiences and how does the construction of sexuality vary in relation to their menopausal status, level of education, religion and occupation?

8.3.1. Introduction

Findings suggest that the sexuality of middle-aged women was guided by a heterosexual script and inhibiting sexual discourse that affected their sexual agency and capacity to negotiate their sexual needs and concerns. This confirms the fact that sexuality is not conceived as a natural phenomenon that exists independently of the social and cultural forces. It is multidimensional and has a complex nature.

8.3.2. Sexual socialisation

Sexual socialisation reflects the development of women's sexual self throughout the milestones from childhood to adulthood and elderly (Gagnon, 1990; Longmore, 1998). Sexuality is rather acquired and transformed through sexual knowledge, beliefs, attitudes, meanings, ethics and values women receive from the family and society. The sociocultural symbols and meanings and the interactions with the others shape women's sexual feelings and behaviours and design their sexual scripts. At their early age, middle-aged women of this study were socialised to respond to social expectations, integrating all the taboo and stigma around sexuality and acting upon to get rewarded.

8.3.2.1. *Inhibiting sexual messages*

Middle-aged women reported that in their childhood sexual socialisation was virtually conveyed by the mothers, whereas the role of the schools was negligible and limited to the reinforcement of the social order. It would be doubtful to attribute socialisation exclusively to the influences of a single person or limit it to one source. Nevertheless, this might be plausible in view of the restricted environment within which the women grew up and where sexual discourse was considered shameful. In congruence with the literature (Daniluk, 1993; Holland *et al.*, 1998; Kadri, Alami and Tahiri, 2002; Averett, 2004; Fields 2008; Connell and Elliot, 2009; Hoga *et al.*, 2010), women's accounts reveal that the messages received in their early age are disempowering, perpetuating the sexual double standard and carrying discriminatory discourses. Women's sexuality is associated with modesty and regarded as their social capital. They are condemned if they show sexual interest or if they translate their sexual attraction to sexual action. Thus, they hide their sexuality and show an invalidation of their sexual self as it is difficult to reconcile sexual pleasure and morality. According to Daniluk (1993), mothers could not admit their daughters' sexuality when theirs failed; they implicitly transfer to the daughters their own sense of shame and sexual devaluation.

However, men are socialised to be sexually experienced and competent and their sexual adventures are tolerated and even praised as reported by women of this study and others (Zhang and Locke, 2002; Wiley and Wilson, 2009; Awwad, *et al.*, 2013). Some authors

suggest that men internalise the hegemonic masculinity since their childhood and wish to reinforce it by a sexual education that specifically addresses the masculine elements of the heterosexual script characterised by men's power and women's responsiveness (Hyde *et al.*, 2005; Forrest, 2010). A powerful masculinity grants men privileges; but it probably makes them vulnerable to the constant challenge to prove their virility. Their ego is threatened when their sexual performance is not satisfying. Suad Joseph (1994) elucidated the gender-based social structure that affects the expression of sexuality by exploring the female-male dynamic relationship between siblings in a Lebanese neighbourhood. She concluded that from childhood, brothers are encouraged to develop masculinity, while sisters learn domestication and feminisation. These discriminatory scripts constitute a clear violation of human rights. Women's right to sexual pleasure remains taboo; a silent discourse even for the feminist movements (Dialmy and Uhlmann, 2005).

In contrast to the disabling messages, in other contexts, dissenting voices and encouraging views are reported. Interviews with heterosexual midlife women revealed their empowerment and resistance (Meadows, 1997). Feminist women were identified as more 'erotophilic' than non feminist (Bay-Cheng and Zucker, 2007) and women exposed to positive sexual messages had higher sexual arousal in comparison to those exposed to negative messages (Kuffel and Heiman, 2006). These different views imply that women's sexuality could not be preconceived as it is developmental and might be positively or negatively experienced. Similar to the observations reported by Mollen and Stabb (2010),

the majority of the participants of this study questioned the restrictions imposed on them. The interviews and focus group discussions were empowering circumstances to reconsider their sexual interactions.

The present study also reveals that sexual discourse is seen by the parents and society as provocative, perceiving young girls in need for protection from men's sexual desire. The few sexual messages address reproductive health issues. Yet, the strongest ones focus on the respect of social values and norms. The mothers who integrate all the inherited religious and social beliefs act as gatekeepers to control their daughters' body and sexual behaviour. This supports Baumeister and Twenge's (2002) views that the suppression of female sexuality is cultural and is mainly ensured by women. At the onset of menstruation, described by other participants as a 'shameful bloody acknowledgement of womanhood' (Daniluk, 1993, p. 62), women of this study recall their struggle to contain their fear of the first menstruation as they were not aware of this developmental change. Presenting the first signs of maturity, they reported that their mothers' main concern was to caution them to stay decent and pure as at this age they might become subject to men's temptations. From these narratives, we can infer that the mothers become only aware of their daughters' protection when they show evidence of reproductive maturity, potentially overlooking children's sexual abuse. Yet, this phenomenon is highly prevalent (Johnson, 2004; Modelli, Galvao and Pratesi, 2012).

Sexuality being constructed by the interaction of the individual with society, sexual thoughts and behaviours are judged based on their appropriateness to social norms (Wehbi, 2002; Askun and Ataca, 2007; Rawson and Liamputtong, 2009). In other words, virginity being regarded as a social phenomenon rather than a personal concern, inhibiting women's sexuality becomes legitimate to control their bodies and preserve the honour of the family. In this way, premarital sex is forbidden (Ege, Akin and Altuntug, 2008; Abder-Rahman, 2009). Otherwise, its cost is high ranging from blame to strict sanctions including disownment of the family, social exclusion and 'honour killing' (Amin and Hossain's, 1995; Wehbi, 2002; Askun and Ataca, 2007; Amy, 2008; Abder-Rahman, 2009; Cook and Dickens, 2009). Even if in Lebanon the statistics about this crime are not evident, it is hard to believe that one third of all violent deaths in Jordan, a neighbouring Arab country, are victims of honour killing (Soussi, 2005). These harsh condemnations are nurtured in patriarchal cultures supported by obstinate religious values (Solberg, 2009; Baydoun, 2011).

Few women in this study, mainly the highly educated and economically independent ones, succeeded in negotiating a new meaning to their sexuality. They challenged the gender-based norms in the access to social, political and economic powers and showed self-control of their sexuality. This affirms the interconnection between sexual and other elements of life and evokes the multidimensional nature of the sexual double standard (Gentry, 1998; Crawford and Popp, 2003).

8.3.2.2. Poor sexual information

Women's difficulty to get access to sexual information seems to be another way to control their sexuality and perpetuate their inexperience and disable their sexual self. This assumption is supported by other studies (Gupta, 2000, cited in Khan, Townsend and D'Costa, 2002; Badawi, 2002-2003). Sexual awareness is expected to empower women and enhance their agency and self-efficacy. Indeed, these middle-aged women have surpassed the age of being offered sexual education; yet, they envy the new generation's openness and wide exposure to information. However, they caution about the flawed sexual messages and erroneous representation of women in the media, valuing exclusively the body and 'sexy' appearance. Wood and colleagues (2006) concur that women might be lost between provocative sexual messages and social sexual restraints. This is a particular dilemma in Lebanon which is a mosaic of the Eastern and Western culture and the loose and conservative norms. Contradictory thoughts and behaviours are increasingly witnessed across individuals, families and regions. Thus, women are torn between the two divergent trends. Living sociocultural instability renders women insecure in negotiating their sexual agency.

8.3.2.3. Perpetuating the silence around sexuality

In the current study, women have few discussions about sexuality with their children, mainly with their daughters, whereas they refer their sons to the fathers whose role is negligible. The literature also pointed to the mothers' influence on daughters and fathers'

on sons (DeLamater, 1989, cited in Baumeister and Twenge, 2002); Werner-Wilson, 1998). The current study reveals that the complexity inherent in this parental responsibility is mainly attributed to their a) ignorance of their children's needs for sexual education; b) lack of knowledge and skills to comfortably and adequately address such a sensitive topic; c) fear of altering their parental image with their children; d) not identifying with their sexual socialisation role; e) sociocultural constraints; f) relying on the school to provide sexual education; and g) parent-child gender differences. Similar barriers to parent-children sexual communication are highlighted in the literature suggesting the parents' neglect of the subject (Walker, 2001; Kadri, Alami and Tahiri, 2002; Solomon *et al.*, 2002; Kirkman *et al.*, 2005; Julliard *et al.*, 2008; Hoga *et al.*, 2010; Hyde *et al.*, 2010).

Despite the highlighted barriers, women of this study recognise the importance of early sexual education for several reasons.

- To understand the developmental processes throughout life and the way they affect sexuality;
- To have an awareness of their sexual self that guides their feelings and behaviours;
- To recognise and be attentive to their partner's as well as their own sexual needs in order to have better sexual interactions and experiences;

- To express their sexuality the way they want rather than the way they should; learn how to value their body, listen to their sexual needs and enjoy sex as an essential part of their life;
- To gain agency to protect themselves against sexual violence, sexually transmitted infections and unwanted pregnancies;
- To recognise sexual difficulties and appropriately manage them in order to get a satisfying sexuality.

Another critical finding of this study that surfaces in relation to sexual socialisation is the quasi absence of a father figure. When sexual education is carried out by mothers to daughters only, the father as a masculine model is missing. It seems that this drawback is common as many studies point to the limited involvement of the fathers in this parental role, specifically with the daughters; whereas the mothers were seen as more receptive and supportive (Nolin and Petersen, 1992; Hutchinson and Montgomery, 2007; Bangpan and Operario, 2014). It might be that the fathers avoid the subject because they are unable to address it (Du Bois-Reymond and Ravesloot, 1996). Their limited role contributed to the poor sexual knowledge of the male adolescents who referred to stereotypical and flawed resources like peers and the media (Nolin and Petersen, 1992). However, the fathers' salient role as male figures helped young women gain insights about men and develop agency and easy relationships (Hutchinson and Cederbaum, 2011).

Women of focus group I in this study discussed the importance of the parents' role and authority in their children's sexual socialisation. In support of this finding, other studies stated that the family environment, parent-child communication, parental sexual attitudes and the quality of the parents' relationship largely determine children's sexual attitudes and behaviours (Nolin and Petersen, 1992; Berger and Luckmann, 1996; Dilorio, Pluhar and Belcher, 2003; Brugman, Caron and Rademakers, 2010; Bangpan and Operario, 2014). A systematic review of qualitative research confirmed the family protective role of their young daughters against sexual risks through sexual education (Bangpan and Operario, 2012).

An appropriate sexual socialisation enables women to recognise their sexual self, rendering them more comfortable with the expression of their sexuality and less victims to sexual difficulties.

8.3.3. Mute sexual self

The second core theme of this study reveals that women's 'mute sexual self' is equated with their invisible sexual self as the result of the oppressing patriarchal society. Women's sexual agency is challenged by their inexperience and lack of power, acting upon their husbands' needs. The meaning they attribute to their sexuality is constructed within a mute sexual self.

8.3.3.1. *Frustrating sexual experiences*

Women's narratives are abundantly permeated with resentment towards their parents and the society as they repress them –quoting women– 'muting their sexual feelings and desires'. Sexuality being internalised as shame, many women are not comfortable with their bodies, perceiving them shameful. Given the lack of preparation, women remember their fear and astonishment at menarche and their unpleasant first sexual experiences. Integrating sex as promiscuous and humiliating, it was difficult for them to all of a sudden awake their sensuality to prove their sexual selves. What was forbidden before marriage became legitimate and a must after it. Having sex was perceived as a violation of the internalised social beliefs and the values associated with a pure woman. In this regard, Derflinger (1998) postulated that guilt comes when the internalised sexual values are dishonoured. Based on her research and experience as a clinical psychologist, Badawi (2002-2003) reflected on this ambivalence among Lebanese women relating it to the taboo around sexuality.

In support of findings, it seems that women with divergent sociodemographic and cultural backgrounds share common sexual concerns. For instance, ignorance and discomfort at the entry to marital life imbued the narratives of Bangladeshi and Brazilian women (Khan *et al.*, 2002; Hoga *et al.*, 2010). This situation resulted for many Bangladeshi into forced sex that affected them forever. It is plausible that these women were sexually ignorant at the time of their marriage since 74% of them got married before the age of 20 and 89%

had maximum six years of schooling. Yet, getting married in their twenties and having a considerable level of education did not shield many of the Lebanese and Brazilian women from the challenges of their first sexual experiences as well as forced sex. However, Brazilian women who were sexually prepared perceived sexuality as an attribute to human beings and a natural part of their life (Hoga *et al.*, 2010).

8.3.3.2. *Contrasting sexual expectations and experiences*

Findings suggest that women have different expectations and outlooks concerning male and female sexuality. They position theirs in a broad context that encompasses the body and mind and describe their sexual satisfaction as contextual rather than being genitally focused. However, their expectations are in conflict with their actual sexual life and interactions with their husbands.

Conceived within a heterosexual relationship, women describe sexuality as an exchange between the two partners in an environment of love, attending to one another's needs, as well as avoiding sexual violence and unpleasant sexual behaviour. Other studies suggest that an intimate, romantic, trustful, safe and respectful relation enables women to exchange love, strokes and kisses with their partners (Tiefer, 1991; Basson, 2001b; Levine, 2002; Graham *et al.*, 2004). Sexual intimacy is particularly a key element of midlife women's sexual functioning and fulfilment (Daniluk, 1993; Baumeister and Bratslavsky, 1999; Birnbaum, Cohen and Wertheimer, 2007). Otherwise, sexual and relational

satisfaction is compromised (Birnbaum, Cohen and Wertheimer, 2007). Supporting this assumption, findings of this study assert women's dissatisfaction because of the poor communication and asymmetric relationship within sexual life. Interiorising sex as a taboo and missing sexual literacy, sexual discourse and exchange between the spouses is less likely to happen.

In parallel, women perceive men's sexuality as physically oriented; the most important is to get their desires met without caring about their partner's feelings or suitable conditions for sex. The literature abounds with findings that support women's views assuming that men's sexual drive is higher than women's (Kadri, Alami and Tahiri, 2002; Leiblum, 2002; Nazareth, Boynton and King, 2003; Richters *et al.*, 2003). Thus, the number of women who consent to have sex without sexual interest is remarkable in this study, confirming their mute sexual self. Some authors term this behaviour 'consensual unwanted sex' and 'compliant sexual behaviour' (Walker, 1997; O'Sullivan and Allgeier, 1998; Impett and Peplau, 2002). 'Having sex for other's pleasure' is common across women in this study and other studies (Nicolson and Burr, 2003; Dobkin *et al.*, 2006; Mollen and Stabb, 2010). This is striking and leads to a paradox in women's views as all of them recognise the importance of sexuality in ensuring the wellbeing of the two partners assuming that if sexual life is good, the overall life is good. The importance women grant to sexuality resonates with the World Health Organization (2006) definition, which attributes to sexuality a central dimension in an individuals' life.

The idea that women engage in sexual intercourse to please their husbands probably underlies the notion of men's virility which is equated with their pressing needs and women's subordination and readiness to assist them. It is also plausible that women assert their sexual self through the others' satisfaction and perceive their sexual needs as secondary to men's. Perceiving women's sexuality as emotional and reactive and men's as physical and compulsory is interpreted as another aspect of the sexual double standard (Muehlenhard and McCoy, 1991). Indeed, gender-based differences exist in sexuality; however, denying men's emotions and reducing their sexuality to an instinctive nature negates the multidimensionality of sexuality. This constitutes a major bias that should be avoided. In line with these interpretations, other authors contend that men's sexuality is not necessarily as stereotypical and genitally-focused as commonly portrayed; variations in their sexual conceptualisation should be considered (Kleinplatz, 2011; Mitchell, Wellings and Graham, 2014). This variation should be acknowledged among women too. For instance, some women in the present study avow their pressing need to enjoy sex in parallel with their partners, while others do not. Giving priority to sex would probably stimulate women to negotiate their sexual needs and gain agency. Sexual function varies depending on each person (Kleinplatz and Menard, 2007; Impett *et al.*, 2008; Mollen and Stabb, 2010; Murray, Sutherland and Milhausen, 2012). Thus, it would be important to consider men's and women's specific context and circumstances when attempting to address their sexual concerns.

Another finding of this study is that sexual intercourse is imperative and women's status as sexual beings is valued through the heterosexual relationship and the penetrative sexual act as similarly argued by other authors (Gavey, McPhillips and Braun 1999; Bogart *et al.*, 2000). Women defining their sexuality as rather emotional but affirming themselves through the imperative coitus shows the ambiguity between their sexual expectations that are female-centred and their experiences, primarily framed around men's sexuality. It might also be that women integrate a compulsory heterosexuality as sexual pleasure is incongruent with the construction of their own sexuality. Social sciences and feminist researchers assert the internalised biological nature of sex that is primarily expressed by penile-vaginal intercourse (Ussher, 1993; Shibley-Hyde and Jaffee, 2000; Nicolson and Burr, 2003; Tiefer, 2004; Wood, Koch and Mansfield, 2006). Knowing that this sexual behaviour is the ideal for men to achieve orgasm, it is not necessarily so for women (Tiefer, Hall and Tavris, 2002; Nicolson and Burr, 2003). It is worth noting that women in this study did not openly talk about their orgasm and the way it is achieved. Their focus was on sexuality in general and the meaning they attribute to it within their relationship. Because of the sensitivity of the subject, it was difficult to obviously discuss this aspect of their sexual life. Sexual function and orgasm ought to be explored in depth in future studies.

8.3.3.3. *Middle-age and changing sexuality*

Many women in this study admit the decline in sexual interest with ageing while asserting the persistence of men's sexual needs and performance. Gonçalves and Merighi (2009) note that the perception of sexual life as a reciprocal exchange with the partner takes into account the partner's sexual performance that might be compromised at midlife and later by acute and chronic health conditions. The lack of recognition of the middle-aged women in their sexuality contravenes their wellbeing (Azar, Kroll and Bradbury-Jones, 2016). Many of them reflect on the physical, emotional and mental distress experienced during this period making them unsure about their feelings towards themselves and their husbands. Internalising the cultural ideals that connect sexuality with youthful desirable femininity, some women express their fear of losing their menses and thus their attractiveness. Women's feelings and negative perceptions of menopause are similarly reported by others (Binfa, Robertson and Ransjo-Arvidson, 2009; Goberna *et al.*, 2009; Yang *et al.*, 2016). Daniluk (1993, p. 63) assumes that 'clearly, the reproductive cycle represented a connection to womanhood; a connection born out of shared experience and reality'.

Like sexuality, menopause is a subjective experience that is multidimensional and is biologically, psychologically and socially constructed. Although affected by hormonal changes, this transition in women's life varies across cultures and according to individuals' characteristics, life style, attitude and knowledge about menopause (Boulet *et al.*, 2008;

Hunter *et al.*, 2009; Huang, 2010). Thus, an association exists between the attitude towards menopause and the severity of the menopausal symptoms (Busch *et al.*, 2003; Ghaderi, Ghazanfarpour and Kaviani, 2010; Nosek *et al.*, 2010). A qualitative study by Murtagh and Hepworth (2005) suggests that menopause resonates with a social constructionist understanding. This assumption challenges the biological meaning attributed to sexuality as represented by the body image and the standards of young, beautiful and sexy women.

The gender role expectation and perception of self by others constitute another cultural bias that is reinforced by the negative media messages (Berger and Forster, 2001; Ekstrom, Esseveld and Hovelius, 2003; Bellamy *et al.*, 2011). This might explain the reluctance of some women in this study to claim their sexual needs or negotiate their sexual agency believing that the menopause is incompatible with the notion and practice of sexuality. As sex serves crucial functions in the marital and family life, quoting one participant, '*what was uniting us died*', some women suggest the use of medical therapy that counteracts the effect of ageing on sexual function overlooking the multidimensional aspect of sexuality. Lodge and Umberson (2012) note that although marital sex of mid-to-later life couples declines in frequency, many claim a better quality of sexual relationship. The authors conclude that the couples have 'less frequent, but better, sex' (p. 7). Other studies suggest that with menopause, some women have increased sexual desire and activity and their orgasm improves (Hinchliff, Gott and Ingleton, 2010; Yang *et al.*, 2016).

Nowadays, the stereotypes about sexuality and ageing and the asexual portrayal of old people have been challenged (Gott, 2006). Yet, sexual medicalisation constitutes another emerging problem in women's sexuality that is discussed in the next theme, sexual difficulties.

Paralleling the perception of sexual loss, other women in this study confirm the development of their sexual maturity and self-confidence with ageing. Their assertiveness helped them gain sexual agency and enjoy sex more than before with no fear of getting pregnant around menopause. Analogous reflections are reported by some midlife Chilean women (Binfa, Robertson and Ransjo-Arvidson, 2009). In reference to one participant of this study, 'women should believe in themselves to let others believe them'. Sexual self awareness is mainly encountered among women who have higher education levels, economic independence and wide social exposure. From these findings we can infer that sexuality of the middle-aged women would be more affected by sociocultural determinants than by menopausal changes. In support of this inference, women do not identify specific menopausal symptoms that alter sexuality. They rather link sex with ageing and their perception is probably socially constructed. Thus, climacteric symptoms do not necessarily affect sexuality. Congruent with this view, Hinchliff and Gott (2008) explain that the meaning attributed to physical changes and ageing as social constructs determine the way sexual life is influenced rather than the menopause by itself. Other studies also conclude that sexuality is rather affected by life style, health issues and

sociocultural factors than by menopause per se (Winterich, 2003; Avis *et al.*, 2009). Thus, women who report positive perceptions, comfort and esteem regarding their body are more likely to enjoy sexual desire and arousal (Graham *et al.*, 2004; Seal, Bradford and Meston, 2009). It would be interesting to examine the way Lebanese women look at menopause.

Marital status is another sociocultural factor that affects the sexuality of women of this study. Only one woman who is divorced revealed her sexual assertiveness. Being active outside home and economically independent might have helped her negotiate her sexual agency. This is not the case of a single woman who has similar characteristics but identifies herself as asexual. The discrepancy in women's views is another indicator of the complexity inherent to female sexuality (Azar, Kroll and Bradbury-Jones, 2016). Furthermore, the three widowed women of this study claim their virtuosity as per conformity with social rules despite their differing backgrounds. In reference to Gott (2005), women become 'sexually retired' after the death or incapacitation of the spouse.

In light of findings, it is evident that the mute sexual self and compliant sexual behaviour constitute a social reality within the Lebanese context. Many assumptions matching examples from the literature provide more insights into the meaning of women's sexuality and the way it is shaped by personal experiences, relational frame and social discourse. These assumptions are:

- First, one might assume that women are comfortable with their mute sexual self and submission privileging their sacrificing role regarded as a social value. The same trend has been persistent for decades as a study by Chamie in 1977 asserts that Lebanese women's engage in the sexual act just to satisfy their husbands. This is similarly reported by other studies suggesting that women have been socialised to be sexually naïve and passive, having sex to please others rather than themselves (Averett, 2004; Askew, 2007). Women in this study interpret this role as an innate female quality that is perpetuated from the grandmothers to the mothers and daughters. They may perceive themselves as selfish or audacious if they act on their needs or claim them. Wood and colleagues (2007) criticise the gender-based sociocultural rules that support men's needs whereas they are disempowering for women. Yet, self-sacrificing and 'the body-for-other' are women's characteristics that Ha (2008) values interpreting their behaviour as a way to protect the family rather than an expression of sexual passivity. A religious sublime meaning is attributed to Muslim women's devotion to their husbands (Khoei, Whelan and Cohen, 2008; Janghorban *et al.*, 2015). Nonetheless, these authors relate women's submission to sociocultural rather than religious rules. Women's sacrifice has an important social significance within the Lebanese context where marriage is a powerful institution and the family is the core of the society. Attributing a family value to sexuality results in women's fear and self-blame in case they miss the husbands' needs.

- In the second assumption, women might exchange sex for benefits assuming sex's function as a marital unifier and family stabiliser. Many of them announce using sex as a strategy to enhance their agency and keep their husbands responsive to their personal and family needs. This corresponds to the social exchange theory where women expect to gain power by offering sex (Baumeister and Twenge, 2002). Their compliance with sexual duties undermines their invisible power to protect the family. Studies in the Middle-East and Arab world indicate that women are submissive to avoid their husbands having affairs (Khattab, 1996; Wikan, 1996; Guessous, 1997; Fahmy, El-Mouelhy and Ragab, 2010). Yet, Agunbiade and Ayotunde (2012) interpret women's attitude as gender-based sexuality. It is plausible that the sexual double standard operates in both ways that serve men and women even if their purposes are different.
- The third assumption reports on women's claim of having sex because it is imposed on them by social norms and religious rules. Some of them internalise the social scripts and others struggle between their rights and the traditional values, paralleling attitudes of young university Lebanese women (Daouk, 2006). And if for Muslim women, sexual obedience is a means of worshipping *Allah* (God), for many Christian women, it relates to Christian marriage that in Lebanon inflicts a marital engagement that is hard to break. In both cases, women are submissive and their sexual decision making is influenced by the internalised patriarchal constructs of their role. In such circumstances where women are marginalised and economically and socially insecure, they are more

likely to be exploited (Meleis, 2005) and less likely to negotiate their sexual agency (Wood, Mansfield and Koch, 2007). Likewise, some participants of this study reveal that their submission and exposure to the husbands' abuse relate to their precarious socio-economic resources, their need to let their children grow up in a family environment and the stigma associated with separated women. In view of their lack of power and resources, they surrender. This again underlies the multidimensional nature of the sexual double standard that is interpreted in relation to the socio-cultural expectations of men's and women's sexuality.

- In the fourth assumption, women obey their husbands out of loyalty to them as they represent the authority of the household. Probably the patriarchal norms are so pervasive that women are unable to voice their needs or are unconscious of their inhibition. Fake orgasm is common to escape the husbands' embarrassment and intimidation especially when they have poor sexual performance. The literature shows that women might be disturbed if they could not ensure their partners' needs rather than theirs (Murray, Sutherland and Milhausen, 2012) and see their orgasm as secondary to men's (Braun, Gavey and McPhillips, 2003). Thus, they pretend orgasm to avoid disturbing the relation or intimidating their partners (Roberts *et al.*, 1995; Cacchione, 2007). These evidences evoke the idea that women learn how to dissociate themselves of their context and how to control themselves to respond to the others'

needs. Thus, faking an orgasm might be equated with a muted sexuality, but as theorised by Jagose (2010), it might also reflect an act of agency.

- In the fifth assumption, it is possible that women enjoy sex silently while claiming a 'servant' position. During the interviews, many of them found the occasion to critique the inherited beliefs and stereotypes that drive their sexual life and prevent them from expressing their sexual desires. Thus, revealing their sexual self might be intimidating and a source of shame and self-blame. El Saadawi (2007) wrote that Arab women who do not exhibit their sexual pleasure are respectful as they represent the ideal social image; otherwise, they are considered as loose women or whores. In patriarchal societies, women do not act upon their needs; the acceptable degree of sexual pleasure and satisfaction is socially determined (Laumann, Paik and Rosen, 1999; Safarinejad, 2006). Expressing their sexual desire and enjoying sex might be interpreted as a violation of the rules. Two women of this study totally disapprove women's sexual emancipation confining themselves to their role as mothers and obedient spouses. These women seem to deeply internalise their scripted role and cannot conceive female sexuality in another way. Being socially constructed, sexuality is shaped in complex ways (Magar and Kambou, 2012).

Last but not least, women did not actively and deliberately contribute to the construction of their sexuality. Their sexual-self was replete with contradictions between their feelings,

perceptions and values and their lived experiences that are male centred. Social norms confined the expression of sexuality within marital life to primarily serve men's needs as if women were robots switching their body on and off on demand. Although many of them have developed their sexual agency to negotiate many life goals, their sexuality is driven by a heteronormativity regulated by the coitus imperative and men's pleasure. Thus, women's sexual difficulties emerged as the result of their inhibited sexual self, the men's sexual problems, the quality of the relationship and other contextual burdens.

8.4. Sexual difficulties

This part of the chapter discusses the third research question:

3. How do women describe their sexual difficulties and the factors that affect their sexual activities and interactions?

8.4.1. Introduction

Around one third of the participants (17 out of 52) expressed sexual difficulties - experiencing unpleasant and distressing sex- at some points of their life. Although this estimation is not small, it is remarkably low in comparison with epidemiologic results that identify 59% of sexual problems among Lebanese women of 45-55 years (Obermeyer, Reher and Saliba, 2007). The discrepancy in findings probably relates to the different methodological approaches. In the present study, women report on the sexual difficulties that they perceived and experienced throughout their lifetime. However, in the study by

Obermeyer and colleagues, women's feedback is limited to a checklist of symptoms experienced during a specific time period. There is increased evidence that female sexual problems constitute an international concern. Yet, the inflated prevalence rates might be meaningless if the definition of female sexual problems remains debatable among scholars and scientists.

In this study, women' sexual difficulties did not remarkably vary in relation to their backgrounds, further asserting their multifactorial nature that is shaped in such a complex way that it would be simplistic to reduce to one single cause or criterion. It is difficult to understand these problems in isolation of the context in which they are entrenched (Meston and Bradford, 2007; Bellamy, Gott and Hinchliff, 2013). Being contextually constructed supports the 'New View' model of women's sexual difficulties (Kaschak and Tiefer, 2001) as well as the DSM-V (APA, 2013) update. Findings of this study challenge the medicalised definition of sexual difficulties considering them as sexual dysfunction. For instance, many women who identified a lack of sexual interest did not seem to be distressed or worried about the subject. Thus, labelling all women who express sexual disinterest or who do not have pleasure in sex as having sexual dysfunction or being distressed -as biologically defined- is misleading.

8.4.2. Sexual unawareness and misconception

Women in this study mainly report difficulties with sexual interest and implicitly pleasure. Some authors relate the lack of sexual desire and the failure to recognise the cues of sexual arousal to sexual inhibition (Laan and Everaerd, 1995; Basson, 2002). This partly explains why many women in this study do not perceive sexual difficulties as female related. They mainly attribute them to their husbands repeating that '*a woman is always ready to have sex*', '*the man is the problem*' and '*I do not think that a woman develops sexual problems*'. These quotes are examples of the misconceptions women have about their sexual difficulties. Their views are in concordance with their mute sexual self and the patriarchal society in which their sexual life is framed. It is possible that:

- Women deny or lack awareness about female sexual difficulties, accusing men of being the vehicles of theirs.
- Women act as subordinates to their husbands forgetting what they feel, want and need for themselves.
- Women are too shy to report on their own sexual problems.
- Women are focused on men's sexual functioning and performance within a heterosexual relationship that is driven by penetrative sex.

Women's lack of perception of female sexual problems might explain why very few of them report vaginal dryness with menopausal changes and all deny any related sexual

discomfort as mentioned earlier. Only one expressed her embarrassment of dyspareunia that she overcomes by using lubricants. During the time of the interview, nearly half of the participants (25/52) reported that they had entered the perimenopause/menopause period characterised by climacteric symptoms. Claiming not to have experienced vaginal dryness and dyspareunia might also affirm the sociocultural conceptualisation of menopause and its symptoms.

Indeed, women's sexual function and dysfunction are affected by menopause. But, they are also associated with many other factors like women's attitude towards menopause (Jamali *et al.*, 2016); long-term relationship with the husband (Badawi, 2002-2003; Gott and Hinchliff, 2003a; Ibrahim, Ahmed and Sayed Ahmed, 2013); different sociocultural traditions and ethnicities (Heiman, 2002; Lo and Kok, 2014; Jamali *et al.*, 2016); chronic health problems and difficult economic and social conditions (Ibrahim, Ahmed and Sayed Ahmed, 2013), male sexual problems, older age, alcohol consumption and extramarital affairs (Nelson, 2006; Yanez *et al.*, 2006; Rosen and Althof, 2008). These factors may exist in addition to the genital changes that occur during menopause (Avis *et al.*, 2009; Yang *et al.*, 2016).

Due to their lack of awareness more than half of the women were sexually gauche at marriage and had unpleasant sexual experiences. As an example, one participant has suffered of vaginismus for many years. Although she is a psychologist, she associated her

problem to a biological cause amenable to medical treatment and dismissed that 'it was all in her head' as she realised after two years of suffering. Sexual problems being not commonly discussed or associated to physical health conditions, women are less likely to promptly identify them. A qualitative study by Bellamy and colleagues (2013) suggests that women's understandings of sexual problems resonate within the medical frame. The authors argued that 'problems arising from psychological difficulties were not seen as real problems and more akin to a good excuse' (Bellamy, Gott and Hinchliff, 2013, p. 3242). Another study revealed that Asian wives are more likely to report their inability to orgasm when they associate it with physical health problems (Lo and Kok, 2014).

8.4.3. Deviation from normative assumptions about sexual behaviour

The husbands' centrality in women's sexual difficulties was apparent in the findings. Women described how erectile and ejaculatory problems and unpleasant sexual behaviours such as forced and anal sex affected their sexual satisfaction. The husbands' role in women's sexuality varies according to the situation; they are conceived as:

- Educators and supporters when women are sexually unaware and in need of assistance, thus helping some of them assert their sexual selves.
- Abusers whose unpleasant sexual behaviours become a source of women's suffering.

- Selfish individuals who avoid help-seeking for their ejaculatory and erectile problems and overlook their wives' sexual needs.

As suggested by the present and other studies, women's sexual fulfilment is male-centric (Nicolson and Burr, 2003; Bellamy, Gott and Hinchliff, 2013). Sexual life being genitally focused, it seems that the majority of women in this study are valued through their capacity to engage in sexual intercourse. Their behaviour asserts the power of heteronormativity. In line with these findings, women with vulvodynia perceived themselves as 'genderless', 'fake women' and 'inadequate women-partners' (Kaler, 2003; Ayling and Ussher, 2008). Women's inability to have penetrative sex and satisfy their partners engender feelings of guilt shame, low self-esteem and diminished sexual desire (Lavie and Willig, 2005; Ayling and Ussher, 2008).

The deviation from normative assumptions about sexual behaviour - forced and anal sex- does not correspond to women in this study to the 'real sex' as internalised and shaped by the sociocultural rules. Anal sex -defined in Islam as a perversion- appears to be of particular concern for Muslim women; it is illegitimate and justifies the divorce. Being embarrassed, women negotiated their sexual agency in indirect ways by avoiding sex or letting their husbands believe that this behaviour is unhealthy. After years of patience and tolerance, one participant who is economically independent confronted her husband and refused to have sex with him. In other words, women face sexual difficulties because they

have sex they do not want, but are unable to refuse it for relational and sociocultural reasons.

Another sexual difficulty encountered by women in this study is their husbands' poor sexual performance (erectile and ejaculatory problems). These male disorders that could also be physical or relational (couple's difficulties, mismatch, loss of attraction) are reported by previous studies as significant risk factors for women's sexual problems (Zhang and Yip, 2012) like orgasmic and lubrication difficulties (Öberg and SjögrenFugl-Meyer, 2005), sexual disinterest and dissatisfaction and less sexual activity (Deeks and McCabe, 2001; Fisher *et al.*, 2005). In a study by Walter (2000), women stopped having sex to avoid unpleasant and unsatisfactory sexual relations. The predominant conceptualisation of sexual life as equivalent to the vaginal-penile intercourse is a challenge for men and women when they have poor performance. Women's capacity to negotiate sexual fulfilment away from the genitally focused sexual behaviour and the 'absolute imperative' is fundamental. Another deficiency is that erectile problems are usually studied and addressed based on the perceived miraculous effect of Viagra reinforcing an instinctive and erroneous view of men's sexuality. This is probably done on purpose to sell pharmaceutical products (Moynihan, 2005).

For women in this study, sexual distress is reinforced by their husbands' resistance to admit the men's sexual problems and seek help. Rather than voicing their concerns, they

silently shoulder their husbands' burden and accord particular attention to their husbands' ego at the expenses of their own wellbeing. A paradox surfaces between women's portrayal as sexually passive and submissive and their responsibility to protect their husbands of social stigma as their sexual performance is equated with their masculinity. Women might also interpret men's poor sexual performance as their own failure questioning their femininity and seducing capacities. In all cases, having poor resources and internalising traditional social and religious values, women bear silently and accept their situation as their lot in life. This might be the price of their marital stability. In support of findings of this study, the literature postulates that women relate their partners' erectile problems to their own body (Bellamy, Gott and Hinchliff, 2013) and that because of gender inequalities, they devote themselves to their husbands and take in charge the husband's emotional and sexual concerns and difficulties (James, 1989; Cacchioni, 2007; Bellamy, Gott and Hinchliff, 2013). It is worth conducting more research that explores how men perceive their sexual problems and how these problems affect women's self perception and overall sexual satisfaction.

8.4.4. Quality of the relationship

The quality of the relationship is central to women's experience of sexual difficulties. Missing the intimacy, affection, attentiveness and respect, -quoting one woman- '*sex becomes mechanical and leads to total sexual disinterest*'. Thus, many women perceive themselves as sexual objects for their husbands' pleasure as well as victims of their moral,

physical and sexual abuse. Basson (2000; 2001b) suggests that sexual life and intimacy are mutually dependent as one affects the other; when sexual activity does not provide women with affection, they are not encouraged to have sex. The claim of some women in this study that sexual life is not worth the price if the marital relationship is not good is supported by other qualitative (Ayling and Ussher, 2008; Bellamy, Gott and Hinchliff, 2013) and quantitative research (Bancroft, Lotus and Long, 2003; Tehrani, 2014). The violation of women's ideals inhibits their feelings, mutes their sexuality and produces sexual problems and dissatisfaction. An effective partners' communication about their sexual and general life issues has a great effect on the quality of their relationship that in turn positively affects their sexual satisfaction and reduces sexual difficulties.

8.4.5. Daily life events and stressors

Daily life stressors inherent to personal and family burdens are additional contributing factors to the sexual difficulties of women in this study. Assuming different roles as wives, mothers and working outside home may overload women and affect their sexual interest. In a list of pressing needs, the majority relegates their sexuality to a second plan. Many of these contextual factors have been reported in previous studies (McVeigh, 1997; Thompson *et al.*, 2002; Badawi, 2002-2003; Callahan, Sejourne and Denis, 2006; Sims and Meana, 2010; Noonil, Hendricks and Aekwarangkoon, 2012; Bellamy, Gott and Hinchliff, 2013). In their discussion about the contextual factors of women's sexual problems, Bellamy and colleagues (2013) refer to Maslow's (1943) 'Hierarchy of Needs' to reflect on

the importance women attribute to sex in relation to other matters. This means that when women face problems and difficult circumstances and pressing issues are not met, sexual fulfilment is difficult to achieve. This potentially results into sexual difficulties.

An additional factor relates to the reproductive health burdens particularly the infertility problems which pressure women to engage in coitus to get pregnant rather than to enjoy sex. In reference to the literature, a symbiosis exists between infertility and sexual difficulties (Aggarwal, Mishra and Jasani, 2013; Bakhtiari, Basirat and Nasiri-Amiri, 2016). Therefore, women's inability to conceive leads to emotional problems that in turn alter sexual functioning. Health professionals should pay close attention to this interaction in caring for women with infertility problems.

Low self-esteem resulting from obesity was exemplified by one participant as producing low body-image, shame and depressed moods that all led to sex avoidance. As recounted by this woman, her distress was doubled as she forced herself to have sex to please her husband, but she was unable to sufficiently respond to his needs. The perception of herself is an example of the objectification of the female body equating beauty and thinness with sexual desirability. In a heterosexual experience, concern about self-body image, weight, attractiveness, physical condition and general well-being affect women's sexual functioning and satisfaction (Dove and Wiederman, 2000; Weiderman, 2000; Pujols, Meston and Seal, 2010).

Findings of this study support the 'New View' model that describes female sexual difficulties based on broad areas that encompass the physical, psychosocial and cultural elements of women's lives. They contest the reductionist view articulated around a dichotomous approach to sexual function or dysfunction criticised by feminists and social science researchers (Bancroft, Loftus and Long, 2003; Moynihan, 2003; Levine, 2007; Waldinger, 2008; Tiefer, 2010). Findings also contest the definition of sexual problems as the deviation from the 'natural sexual function' while contextual factors are marginalised. Tiefer (2012) argues that these factors are overlooked as they are not scientifically evidenced. However, a clinical classification of sexual problems gives eligibility for medical interventions based on social consensus rather than on scientific and accurate diagnosis (Tiefer, 2006a). Moynihan wonders whether the 'social construction of illness is being replaced by the corporate construction of disease' (Moynihan, Heath and Henry, 2002, p. 886). The biomedical perspective ignores the individualised experience of sexual problems and limits them to predetermined standards that could not be systematically applied to all. As women's sexual responses differ from one another (IsHak and Tobia, 2013), their sexual difficulties are not uniform. Women's understanding of their sexual life as normal and tolerable or abnormal and problematic is crucial. Looking at the subject from their perspective is expected to reduce the confusion and lead to more reliable implications for sexual health policies and practice.

8.5. Conclusion

Findings suggest that a 'mute sexual self' characterises women's sexuality. This has emerged as a core theme resulting from an invalidating sexual socialisation and probably leading to 'mute sexual difficulties'. Women's sexual agency is negotiated within a heterosexual relationship orchestrated by husbands empowered by gender-based norms. Adhering to inhibiting sexual scripts, women value themselves through a sacrificing role and gain agency by fulfilling their husbands' pleasure. All of them perceive sexual life within a caring relationship and suitable context while few assert their sexual rights and needs.

CHAPTER IX. DISCUSSION OF FINDINGS OF THE ANALYSIS IN REGARDS TO HELP-SEEKING FOR SEXUAL DIFFICULTIES AND NURSES' AND MIDWIVES' ROLE IN SEXUALITY-RELATED CARE

9.1. Chapter overview

This chapter discusses women's accounts about help-seeking for sexual problems and the facilitators and barriers to this behaviour. It also interprets how nurses perceive and experience their role in sexuality-related care.

9.2. Help-seeking for sexual difficulties

This part addresses the two research questions about help-seeking for sexual difficulties:

4. What are the barriers and facilitators that women identify in relation to seeking help for sexual difficulties?
5. What are the different sources of help and the preferred characteristics of the helpers that women consider important in managing sexual difficulties?

9.2.1. Introduction

In Lebanon, there are no studies about help-seeking. Problems with accessibility to and affordability of healthcare services prevail although the healthcare system is highly developed and Lebanon is a party of many international treaties that stipulate human

rights to health. Within the Arab Middle-Eastern who share with the Lebanese population many beliefs and traditions, studies suggest that help-seeking often happens at an advanced stage of a disease when symptoms tend to become intolerable (Al-Krenawi and Graham, 2000; Al-Krenawi, Graham and Kandah, 2000). A systematic review suggests that the delay in seeking help prevails even when the disease is fatal and the survival rate is partly time-related as for instance is the case in 20-30% of women with breast cancer (Richards *et al.*, 1999). Delaying help-seeking is also observed among elderly and chronically ill patients (Liu, Beaver and Speed, 2014). If people are reluctant to seek help for critical health problems, it is not surprising that they are so when faced with sexual problems which are not life threatening. It would be interesting to examine the notion of 'help' in the Lebanese and Arab context and see the way it is perceived in comparison to other populations.

Nevertheless, facing sexual difficulties does not necessarily imply seeking professional assistance or considering these difficulties symptom-based or a deviation of the standards of normalcy. Women's perception of the multifactorial aspect of sexual difficulties reflects the complex and dynamic process of help-seeking, rejecting its dichotomised acceptance-avoidance conceptualisation and admitting its multidimensional nature. Unger-Saldana and Castaneda (2011) define this behaviour as a process that goes beyond the individual capacities to consider the social interactions and healthcare systems as its major components. In this study, three themes emerged in response to the research questions

explaining how the 'Interpretation of sexual problems', 'Beliefs about help-seeking' and 'Sources and quality of help' act as facilitators and barriers to help-seeking for sexual problems. It is worth noting that not all women reported sexual problems or perceived the need to seek help. Thus, some narratives are based on women's experiences and others reflect their perception and attitude about help-seeking.

9.2.2. Interpretation of sexual problems

Defining the problem constitutes a crucial determinant of different help-seeking behaviour models like the Health Belief Model (Rosenstock, 1966; Rosenstock, Strecher and Becker, 1988), Socio-Behavioral Model (Anderson, 1995) and the Information-Processing Model of the Decision to Seek Professional Help (Vogel *et al.*, 2006). Thus, findings of this study indicate that the significance women attribute to sexual difficulties constitutes a core factor of help-seeking. They have a strong desire to seek help when they perceive these difficulties as serious and may threaten marital and family stability. Weighing costs and benefits while assuming that '*sexual problems become family problems*', women are triggered to seek help as a protective measure of the family cohesion. Yet, they might do so to satisfy their husbands whereas few of them would take such an initiative for their own sexual pleasure. In support of these findings, the literature indicates that women are more likely to seek help when they perceive distress, threat and persistence of sexual difficulties (Mercer *et al.*, 2003; Maserejian *et al.*, 2010; Reed *et al.*, 2012; Azar, Bradbury-Jones and Kroll, 2013). As revealed by this study, women's attitude is congruent with their mute

sexual self that is paralleled with the perception of men's sexual urge and the need to satisfy them to avoid extramarital affairs. It seems that middle-aged women from different sociocultural backgrounds report similar worries that may trigger them to seek help to protect their household (Ling, Wong and Ho, 2008; Binfa, Robertson and Ransjö-Arvidson, 2009; Hinchliff, Gott and Wylie, 2012).

Lack of perception of the nature of the problem or assuming that sexual problems are not female-related would certainly prevent or delay help-seeking. For instance, one participant suffered from sexual difficulties for two years before recognising the need to refer to a professional. As sexual problems are not necessarily physical and attributed to one single cause, they are not easy to recognise. Moreira and colleagues (2008b) suggest that both men and women are more likely to seek medical help when they perceive their sexual problems like erectile dysfunction and lubrication difficulties as physical and best treated by a professional.

Women identify the lack of sexual interest as another impediment to help-seeking. Being valued through their reproductive status rather than their sexual performance (Dejong *et al.*, 2005), it is probable that sexuality becomes secondary for them at the middle-age. Likewise, other studies argue that women are not encouraged to seek help when they do not see their sexual problems as bothersome (Berman *et al.*, 2003; Nicolosi *et al.*, 2006a; Raffi, 2007; Feldhaus-Dahir, 2009; Fitter, Hayter and Wylie, 2009). They ignore the

situation, deny its severity, hope to get a spontaneous recovery or see their case normal with ageing (Brock *et al.*, 2006; Vahdaninia, Montazeri and Goshtasebi, 2009; Donaldson and Meana, 2011).

9.2.3. Beliefs about help-seeking

Women's perception of help-seeking whether it is 'stigmatising - intimidating' or an 'Informed choice' affects their attitude towards this behaviour. A number of them believe that sexual disclosure is a violation of the couples' privacy and commitment to one another particularly when the husbands are accused of sexual problems. Supported by religious beliefs, Muslim women admit that in Islam any revelation of men's sexual problems is '*haram*' [strictly prohibited by the religion]. It is equated with unfaithfulness towards the husband. It is worth noting that Islam is among the monotheistic religions that encourage women to enjoy sexual intercourse and mutual satisfaction with the partner (Kadri, Alami and Berrada, 2010). But this does not appear to be applied as Muslim participants in this study bear silently to preserve their husband's social image. Additionally, high rates of female 'sexual dysfunction' contrasted with low prevalences of help-seeking are particularly found in countries with an Islamic majority (Safarinejad, 2006; Elnashar *et al.*, 2007). This is another indicator of the impact of tradition rather than religion on sexuality. The concealment of the husbands' sexual problems is also asserted by some Christian participants for whom the religious marriage is a sacrament; thus, sexual disclosure is equivalent with a sinful act.

Women's views reinforce gender sexual power imbalance which constitutes a strong barrier to help-seeking. This is obvious in the current study since none but one of the husbands who are perceived as having sexual problems sought help. All denied the problem and apparently refused to discuss or address it, neglecting their wives' complaints and sexual deprivation. Yet, some of them took medication behind their wives' backs. It is not clear whether they consulted a physician or bought the drug directly from the pharmacy. The second eventuality is more probable as self-medication, which is highly prevalent in Lebanon, is less intimidating than the consultation of a professional. Self-management has not often been described in the literature as a component of help-seeking models although this behaviour is very common and ought to be studied. Being desperate, some women timidly referred to a physician in an attempt to solve their husbands' problems. But this was useless since help-seeking requires the individual's positive attitude and intention to manage the problem. Studies about the outcome of help-seeking are scarce and the topic requires more attention.

From findings of this study, we can infer that within the Lebanese patriarchal culture, women opt for self-concealment to protect their husbands' ego. Self-concealment is defined as 'a predisposition to actively conceal from others personal information that one perceives as distressing or negative' (Larson and Chastain, 1990, p. 440). It is a self-regulation to maintain the privacy of intimate personal information about emotions, thoughts, behaviours and events (Barr, Kahnand and Schneider, 2008). Previous studies

suggest that self-concealment is central to help-seeking behaviours (Cramer, 1999; Liao, Rounds and Klein, 2005; Vogel and Armstrong, 2010).

There is evidence that men perceive help-seeking as a stigma (Vogel and Wade, 2009; McKelley and Rochlen, 2010) and see themselves as self-controlled, autonomous and problem-solvers rather than help-seekers (Mackenzie, Gekoski and Knox, 2006). Self-stigmatising is reinforced by the endorsement of a masculine gender role and high social expectation (Addis and Mahalik, 2003; Galdas, Cheater and Marshall, 2005; Pederson and Vogel, 2007) which negatively affects men's willingness and ability to seek help (Mansfield, Addis and Courtenay, 2005). Thus, they do not perceive erectile dysfunction as a health condition to discuss with their physicians (AbRahman, Al-Sadat and Low, 2013). Another study reveals that gender does not predict the decision to seek help for sexual problems (Kedde *et al.*, 2012). Interpreting help-seeking in consideration of the traits of femininity and masculinity is controversial. A binary conceptualisation limits the holistic understanding of gender as a sociocultural construct and builds the perception of help-seeking on misconception ignoring the real determinants of this behaviour

In view of their age and mute sexual self, women too might view help-seeking as intimidating. Accordingly, they avoid discussing the topic or disclosing their sexual concerns and need to have sex out of fear of stigmatisation. They apprehend their husbands' negative judgment and the professionals' negligence of their complaints. Yet,

the belief about the normalcy of help-seeking is reinforced by women's high education level, their awareness about their sexual needs and their capacity to claim them.

9.2.4. Sources and quality of help

Women identify the husband as the first and most important source of help assuming that *'nobody can understand spouses' concerns more than themselves'*. Many of them solve their problems with the careful assistance of their husbands particularly at the beginning of their marital life. In support of the current findings, the 'Global Study of Sexual Attitudes and Behaviors' found that the partner constitutes the most common source of help for women (Moreira *et al.*, 2005a). Women's views stem from the psychosocial understanding of sexual problems that relate to emotional, relationship and contextual factors rather than physical disorders. Similarly, Hinchliff and Gott (2011) think that people do not see sexual problems within the remit of medicine. While these problems are mainly seen as secondary to the husbands' poor sexual performance and improper sexual behaviour, women could not envisage the solution outside the marital relationship. Spouses' communication stimulates the expression of feelings, interest, and preferences (Wood, Mansfield and Koch, 2007), enriches sex life and ensures affection, happiness, better body image and self confidence (Binfa *et al.*, 2009). Paradoxically, spouses' relation is characterised by an inhibited communication. The husbands' lack of cooperation constitutes an overarching concern for women in this study. This could be interpreted in different ways:

1. Sexual communication is believed to grant women agency and power which might not be admitted by men;
2. Men deny their sexual problems and avoid discussing them with their wives by fear of altering their male figure;
3. Men might be indifferent to their wives' distress as their own priorities always come first;
4. Men might be unaware of women's needs and the ways to ensure their sexual satisfaction due to the lack of sexual education and the silence and taboo around sexuality.

The close relatives and friends constitute another venue of informal help for women in the study. Among the 29 countries of the 'Global Study of Sexual Attitudes and Behaviors', this source of informal support was the highest in the Middle East; Algeria, Egypt, Morocco and Turkey (Moreira *et al.*, 2005a). Relatives and friends might be helpful; but since sexuality is taboo, they might carry insufficient and wrong sexual information. Interpreting anal sex within a religious context, one woman referred to a priest considering him the best helper.

On the other hand, one might think that if sexual problems are not medical, why women should refer to a health professional. This assumption would also explain why women's perception of nurses' and midwives' role in sexuality care is controversial. First, as sexual

problems are multidimensional in terms of risk factors, manifestations and consequences, an interdisciplinary approach that includes professionals from different backgrounds chiefly health professionals is warranted. Second, in our Lebanese context, the health professionals are the most common and reliable source of help whether the problems are physical or psychosocial. Their role in referring people to the appropriate helper is fundamental. Third, as sexual problems are taboo and not commonly discussed, it is difficult to recognise and highlight them. The health professionals particularly the nurses and midwives are best suited to help women get aware of their sexual self. They can discuss with them their sexuality, assess, inform, guide, empower and ensure a follow up as needed. This is fundamental at middle-age where women undergo several physical and psychosocial changes that may affect their sexuality. An appropriate assistance helps women understand these changes and meet their needs.

Paradoxically, sexuality-related care is not part of the culture and the clinics and specialists in the field are very few. This is confirmed by women who are unaware about the sources of help for sexual problems; they do not know where to go and whom to refer to. Therefore, the preference is for the gynaecologist as also reported by other studies (Kadri, Alami and Tahiri, 2002; Shifren *et al.*, 2009). It is not surprising to privilege this physician and consider him/her their second choice after the husbands since he/she accompanies women in all their reproductive health events throughout their lifespan. But many women do not perceive the quality of sexual healthcare services which probably

does not encourage them to seek help. They complain of the professionals' lack of competence and neglect of sexuality excluding it from the remit of their practice and taking it for granted that women do not want to talk about these issues. These professionals who are not well prepared and who like women, internalise the taboo around sexuality, would probably be reluctant to comfortably discuss the subject. This seems to also be the case of other professionals in other contexts (Gott and Hinchliff, 2003a; Moreira *et al.*, 2005a; Moreira, Glasser and Gingell, 2005; Wimberly *et al.*, 2006; Harsh, McGarvey and Clayton, 2008; Julliard *et al.*, 2008; Buvat *et al.*, 2009; Laumann *et al.*, 2009; Shifren *et al.*, 2009; Woolhouse, McDonald and Brown, 2014).

Yet, many women in the current study particularly those with low education, refuse sexual health assessment by the professionals considering it unethical. Nevertheless, the literature reports the efficacy of this approach in reducing stigma and increasing familiarity with sexual issues (Wendt *et al.*, 2009) and the likelihood of help-seeking (Moreira *et al.*, 2005b; Laumann *et al.*, 2009). A hostile approach prevents sexual disclosure (Pariser and Niedermier, 1998; Cape and McCulloch, 1999; Julliard *et al.*, 2008) and leads to dissatisfaction and poor sexual health outcomes (Humphrey and Nazareth, 2001; Bagherzadeh *et al.*, 2010).

Conversely and as noted by women in this study, an appropriate professional approach characterised by respect, confidentiality, trust and sympathy encourages them to seek

help. This resonates with findings of other studies (Beach *et al.*, 2005; Fitter, Hayten and Wylie, 2009; Vahdaninia, Montazeri and Goshtasebi, 2009). The female professional is another characteristic that may prompt women to seek help. Gender similarity has been reported in qualitative and quantitative studies as a key factor for sexual disclosure (Dilloway and Hildyard, 1998; Gott and Hinchliff, 2003b; Moreira *et al.*, 2005a; Julliard *et al.*, 2008). Perceived similarities in life experiences reduce potential embarrassment related to sexuality (Gott and Hinchliff, 2003b).

The role of nurses and midwives is timidly highlighted in this study although many women recognise their competence and value their assistance in sexuality-related care. The role of the midwives is particularly acknowledged as sexual and reproductive health is at the core of their practice. Other studies suggest that the midwife is expected to promote sexual health since women perceive her as knowledgeable, trustworthy and reassuring (Haboubi and Lincoln, 2003; Wendt *et al.*, 2009). Being aware of the substantial contribution of nurses and midwives in promoting sexual healthcare, their role was explored identifying the way it is shaped by the personal and sociocultural beliefs and health practices.

9.2.5. Conclusion

Findings point to the interconnectedness between subjective, relational, sociocultural and health-related factors that affect help-seeking and are shared among women from

different backgrounds and contexts. Thus, a comprehensive understanding of this behaviour is crucial to provide women with effective sexuality-related care.

9.3. Nurses and midwives role in sexuality-related care

In the last part of this chapter, nurses' and midwives' role in sexuality-related care is discussed in consideration of the two research questions:

6. Do nurses and midwives perceive their role in sexuality-related care and how do they practice this role?
7. How are nurses and midwives' roles affected by their personal experiences and the healthcare system?

9.3.1. Introduction

This second part of the chapter is focused on the discussion of the results of the two focus groups conducted with 11 nurses and midwives working in the hospital and community. Believing that nowadays holism symbolises healthcare delivery and that sexuality is an integral element of the humans' existence and an indicator of their quality of life, sexuality-related care should be at the core of nursing and midwifery practice. For this purpose, it was necessary to understand how their beliefs about sexuality, the general sexual discourse and the healthcare system impact the provision of sexuality care.

All nurses and midwives situate sexuality in a multidimensional context criticising the taboo around the subject and the sexual double standards. Nevertheless, they have differing views in regard to their role in sexuality-related care. Some are with the idea and others against, mainly because of the lack of knowledge and skills to appropriately address such a taboo and sensitive subject. They escape their embarrassment in addressing women's sexual issues by adopting different coping strategies. They all agree on the need to update the curricula in line of the emerging needs in sexuality-related care to have a more effective contribution in the domain.

9.3.2. Perception of sexuality

Nurses and midwives situate sexuality in a wider context that takes into consideration the physical, emotional and social factors. Framed within a heterosexual relationship governed by love, understanding, exchange, transparency and respect, sexuality ensures women's fulfilment, security and happiness. In other words, sexuality is for these professionals an important indicator of the overall wellbeing even if this is not translated in their daily practice. Similar perceptions are reported by other studies where sexuality is valued as a basic human need that affects individuals' health and wellbeing (Lavin and Hyde, 2006; Vieira *et al.*, 2013). However, Lavin and Hyde (2006) assume that nurses may consider the broad aspect of sexuality to avoid discussing its erotic character. This is plausible given that the perplexity and embarrassment of many participants in verbalising their opinions and the hot debates and contradictory thoughts they had during the group

discussions around the assessment of patients' sexual issues were obvious. The discrepancy among them matches their differing backgrounds and personal experiences. Additionally, nurses' and midwives' views concerning gender-based sexuality do not differ from those of women given that all of them are nurtured in the same patriarchal society. Nevertheless, the professionals voice a feminist position, advocating for an egalitarian relationship between men and women.

9.3.3. Discussing women's sexuality

Nurses and midwives describe women's sexual difficulties as psychosocial, incriminating their sexual inhibition and the couples' lack of awareness. They also recognise the impact of the disease and therapy on sexual function. All agree on the necessity to appropriately handle these difficulties, suggesting a compassionate interdisciplinary approach while avoiding stigmatisation and criticism. But, in fact, few of them have initiatives in the field. Their actual role does not reflect their perceptions of the subject matter. Yet, nurses and midwives who are involved in educational responsibilities and community care show more interest and proactiveness in integrating patients' sexuality care in daily practice and are more self-confident in discussing the topic.

Nurses' and midwives' role is constructed within two differing views, the biomedical care where a physical condition interferes with sexual functioning and holistic care that recognises the multidimensional aspect of sexuality. The competing views between the

hypothetic and pragmatic approach to sexuality-related care are commonly reported in the literature (Hodern and Street, 2007; Vieira *et al.*, 2013). Nurses and midwives acknowledge the difficulties inherent to their role and the need to prepare themselves and overcome the barriers to patients' sexual assessment and management.

Using the PLISSIT Model (Permission, Limited Information, Specific Suggestion, and Intensive Therapy) to respond to patients' sexual healthcare needs, Taylor and Davis (2006) found that nurses (implying also the midwives) are at the first line among the health professionals to whom the patients can refer and get effective feedback. Other authors suggested that nurses are in the ideal position in the healthcare team to deal with patients' sensitive issues like sexuality (Sung, Jeng and Lin, 2011). This was affirmed by many participants. As part of their scope of practice, nurses have the responsibility to inquire about patients' sexual concerns, ensure counselling and guide them to overcome their difficulties (Jolley, 2002; Dattilo and Brewer, 2005). Nurses and midwives can assist their patients to enjoy sexuality considering its multidimensional perspectives. This wider scope resonates with the WHO (2006) definition of sexuality and sexual health and urges nurses and midwives to shift their practice from a narrow focus to a more comprehensive approach. This affirms that even if sexuality is not primarily health related, it is at the core of nurses' and midwives' role and domain of practice. In addition to their unique position in the hospital, nurses and midwives have a community and public health role. Their commitment to the promotion of women's sexual wellbeing is legitimate and part of the

promotion of women's overall wellbeing. Acknowledging that sexuality is a broad concept that encompasses different aspects of women's life in different circumstances, nurses and midwives are expected to develop their knowledge and skills to provide a wide range of services that could be physical, psychosocial, relational and/or cultural.

9.3.4. Muting women's sexuality

The taboo and stereotype around sexuality, the lack of knowledge and skills and the conservative attitude persist and incarcerate the majority of nurses and midwives of this study in an asexual role. A comprehensive literature review reveals that nurses fail to provide cancer patients with appropriate sexual health care because of a series of deficiencies that relate to poor resources and communication skills, misconceptions about patients' sexual needs and priorities, cultural influences and the professional educational background (Kotronoulas, Papadopoulou and Patiraki, 2009). More recent studies support these evidences, concluding that the professionals' deficiencies act as barriers to patients' counselling (Pinar, 2010; Chun, 2011; Oskay *et al.*, 2011; Gölbaşı and Evcili, 2013; Oskay, Can and Basgol, 2014; Mansour and Mohamed, 2015).

Nurses and midwives' misperception of their role is paralleled with the belief that the critically ill patients are not sexually active particularly when they have oncology and mental health problems. The professionals working in these areas assume that the severity of the disease alters patients' interest in sex. Patients' sexual issues are perceived

as less important than other health aspects like cardiac problems, hypertension or medication. Similar attitudes are reported by a qualitative study conducted with senior nursing students (Dattilo and Brewer, 2005). While the condition and treatment can impair libido and energy levels etc. it does not uniformly impact the patient's ability to enjoy sex. On the contrary, having sex and intimacy can have beneficial effects on patients' and partners' relations. Patients with chronic health conditions may have serious sexual concerns and express the need for assistance which is often not provided (Stead *et al.*, 2001; Jaarsma, 2002).

However, the study by Magnan and Reynolds (2006) show that the barriers in assessing patients' sexual concerns are significantly lower for nurses working in obstetrics/ gynaecology versus general wards (medical, surgical, oncology and rehabilitation). These specialised nurses -equivalent to the midwives in Lebanon- give the patients the opportunity to talk about sexuality and are more comfortable in their discourse with them than other nurses. The same study also indicates a non-significant difference between the various levels of nursing education.

The preliminary results of an ongoing quantitative study conducted by Azar and colleagues on a representative sample of the university hospitals in Lebanon suggest that nurses and midwives have major obstacles towards patients' sexual health assessment with the highest percentages found in the medical-surgical units and the lowest in the

maternity units. Their attitude is mainly affected by the 'patients' privacy and lack of readiness to discuss sexual issues' and their 'embarrassment' and 'not making time to discuss the subject'. The sample of nursing and midwifery students in the same study note obstacles of 'time', 'embarrassment', 'culture and religion' and the 'belief that patients expect nurses to ask about their sexual concerns'.

In support of other findings (Haboubi and Lincoln, 2003; Ho and Fernandez, 2006; Arikan *et al.*, 2015), many professionals of the present study are reluctant to address sexuality related-issues assuming that this role is an intrusion into the patients' privacy. Paralleling this belief and as mentioned earlier, many women in this study have a hostile attitude towards the potential health providers' invasion of their sexual life. This confirms the professionals' assumption that the patients should initiate the discussion about sexuality. Lavin and Hyde (2006) believe that due to a traditional culture, women have poor sexual literacy that makes them less tolerant to sexual discussion and in turn, discourages nurses to address the subject with them. On the other hand, some literature states that the patients feel more comfortable if the professionals encourage them to express their sexual concerns; yet, being afraid to alter the respectful therapeutic relationship, the professionals wait for the patients to do so (Waterhouse and Metcalfe, 1991; Waterhouse, 1996; Hordern and Currow, 2003; Yigit *et al.*, 2007; Kim, Kang and Kim, 2011; Mansour and Mohamed, 2015).

These differing views probably relate to the lack of familiarity in addressing sexual issues as part of the general health. The topic remains taboo for the patients and professionals. Many nurses and midwives declare their sexual timidity and inhibition which do not allow them to be comfortable in sexuality care. Their personal attitude is seemingly projected in their professional role, mirroring the cultural perception of sexuality. Not being comfortable with their sexual selves, it would not be possible for them to address their patients' sexual issues. A qualitative study reveals that being shy and embarrassed and lacking the vocabulary to express their thoughts, Iranian women and health providers use euphemisms like 'thing' to reflect on 'sex' and 'sexual intercourse' (Shirpak *et al.*, 2008). Another qualitative study assumes that being comfortable with their sexual self, Brazilian nurses deliver good quality sexuality care (Vieira *et al.*, 2013).

The nurses and midwives criticised their curricula that are characterised by a conservative education that does not prepare them to deliver adequate sexuality-related care. Other professionals highlighted similar complaints and asserted the need to develop their capacities (Ho and Fernandez, 2006; Lavin and Hyde, 2006; Jaarsma *et al.*, 2010; Doherty *et al.*, 2011; Zeng, Liu and Loke, 2012; Yıldız and Dereli, 2012). Only a few of them reported on their satisfaction with their knowledge and performance (Jaarsma *et al.*, 2010; Yıldız and Dereli, 2012). Furthermore, a sample of students suggested the reinforcement of a practice-based education that strengthens knowledge and skills (Walker and Davis, 2013; Tsai *et al.*, 2014).

Organisational factors emerge as other major barriers for nurses and midwives to address sexuality care. These include workload, lack of time, lack of familiarity with women given the short stay in the hospital and the fact that everyone has her own health provider and the lack of privacy in the two bed rooms. These are congruent with findings from other studies (Guthrie, 1999; Stead *et al.*, 2003; Clayton *et al.*, 2008; Nakopoulou, Papaharitou and Hatzichristou, 2009; Kim, 2010; Mansour and Mohamed, 2015). Nurses and midwives in this study also acknowledged their lack of power within a private healthcare system dominated by the physicians. This is assumed to affect their social image that is not well recognised and properly valued, whereas the physician is seen as more knowledgeable, competent and trustworthy. A favourable work environment characterised by privacy, good patient-nurse relationships and communication with sufficient time would facilitate sexual discussion.

Missing the personal and contextual support to provide sexuality-related care, nurses and midwives use different coping strategies to escape their embarrassment.

9.3.5. Coping with embarrassment

Some nurses delegate sexuality-related care to the midwives or physicians. In turn, the midwives often find the gynaecologist the most suitable professional to assume that responsibility. In a study by Yıldız and Dereli (2012), the majority of nurses refer the patients in need for sexuality care to other professionals. Like the participants of this

study, they rely on professionals that they perceive more competent than themselves. While in the present study, the participants suggest mainly referring women to the gynaecologist, or, the psychologist, in the study of Doherty and colleagues (2011), the first referral choice was the general practitioner followed by the psychologist. It might be that the availability of other human resources makes nurses and midwives more willing to refer the patients with sexual needs to them. Otherwise, the patients are left without any assistance (Butler and Banfield, 2001).

Avoidance is another approach nurses and midwives use to escape their timidity and the social stigma associated with sexual discussion. The literature indicates that nurses are used to brush over sexuality and that avoidance is a strategy that is often used in intimidating situations (Valentine, 1995; Guthrie, 1999). Thus, coping alternatives are adopted depending on the context of nurses and midwives. For instance, fearing prejudice, one participant recounts being selective in addressing sexuality related issues although she is a midwife and is expected to be proactive in the field. She believes that showing her sexual knowledge is equated with being perceived as sexually experienced which does not socially correspond to her celibate marital status. We can infer that the marital status affects these professionals' perception and practice of their role in sexuality care. A study by Williams and colleagues (1986) identifies marital status as a potential risk factor; yet, this association is not confirmed among Egyptian nurses (Mansour and

Mohamed, 2015) and Lebanese nurses and midwives (Azar and colleagues, unpublished ongoing study).

Another coping strategy adopted by nurses and midwives is by making a joke of patients' sexual concerns rather than responding to their needs. They justify their reluctance by the complexity of sexuality-related care that requires a lot of education and training which they do not own. Perceiving their limitations, some participants suggest more specialisation in the field. This would probably reduce their intimidation and workload, but it would also fragment the holistic approach to nursing and midwifery care. Related to this finding is the suggestion to train oncology nurses to deal with sexual matters of cancer patients (Canada and Schover, 2005).

9.3.6. Conclusion

In concluding this part, findings indicate that some nurses and midwives interiorise sexuality as a taboo, underestimating their capacity to address this subject and perceiving it as challenging at the level of knowledge, skills and communication. In parallel, other participants who are empowered by their self-confidence and are convinced of the need to address patients' sexuality seem to be proactive and willing to overcome the gaps. Yet, they are challenged by many professional, organisational and other barriers that would have been conquered if sexuality was given its due attention in the nursing and midwifery curricula. The lack of theoretical information and quasi inexistent training are the

overarching concerns of all nurses and midwives of the study, leaving them poorly qualified to address such a complex and sensitive topic. These findings are important in that they inform the elaboration of suggestions entrenched in the Lebanese context to improve nurses' and midwives' role in sexuality-related care.

CHAPTER X. CONCLUSION, IMPLICATIONS AND STRENGTHS AND LIMITATIONS

10.1. Chapter overview

Chapter X ends the dissertation by presenting the study contribution, the implications and suggestions to improve women's sexuality through education, practice and research, acknowledging the strengths and limitations of the study.

10.2. Study contribution

This qualitative study that is underpinned by a constructionist epistemology constitutes a cornerstone in providing a comprehensive understanding of sexuality of middle-aged Lebanese women. It explored the meaning women attribute to sexuality as a sociocultural construct, the conceptualisation of sexual difficulties beyond from the biomedical frame and the pathway to help-seeking for sexual problems accounting for a multiplicity of personal and environmental factors. The study also examined the role of nurses and midwives in sexuality-related care and their subjective perception of the subject considering their close interaction with women.

The meaning women attributed to their sexuality lies at the core of competing family and social norms that prescribe them sexual scripts congruent with the conservative patriarchal structure. Conceived within marital life, women are compelled to live their

sexuality according to behavioural expectations and gender-based stereotypes giving them little room to articulate what they think, feel and want, thus muting their sexual self. Their socialisation into passivity and timidity enhances their ideal social image as pure and obedient spouses to virile and assertive husbands.

Whether they adhere to these stereotypes or attempt to prove their sexual self, women are faced with different challenges that are quite striking, making their sexuality difficult and in conflict. Many influences on women's sexuality are apparent like a) the sexual socialisation into taboo and silence, infusing sexuality with guilt and shame; b) the oppressing social and religious rules reinforced by poor personal resources; c) the traditional asymmetry of gender roles whereby women's sexuality is males-centred; and d) the functionality of sex for women, using it as 'a means to an end' while advocating for a romantic sexuality.

Social scripts mute women's sexual self. This results in a discrepancy between their sexual expectations and their experiences. Their sexuality is driven by heterosexual norms where the penile-vaginal intercourse is paramount aiming primarily at the husbands' satisfaction. Women might have sex they do not necessarily want but which helps them gain agency and power to negotiate other life issues. Despite their disempowering sexual self, women find ways to give meaning to their sexuality that has implications on their general life. Many of them developed their sexual self and asserted themselves as feminine

sexual beings. With ageing they gained self-confidence and leadership roles in their sexual interactions. Their assertiveness to prove themselves is an example of the dynamic and developmental aspect of sexuality and sexual agency.

The study also extended the understanding of women's subjective views of sexual difficulties which stem from sociocultural and relational factors rather than biological deficiencies. An important finding of this study is that women did not consider sexual difficulties as female-related and did not highlight menopausal symptoms as negatively affecting their sexuality. However, menopause was perceived by some of them as a threat for their femininity and attractiveness. Women's subjective interpretation of their sexual difficulties is in accordance with the feminists and social science researchers' views. Although women reported sexual difficulties, they did not perceive themselves as sexually dysfunctional. They rather interpreted these difficulties as the reactions to their environmental factors or their consequences.

Thus, addressing their sexual difficulties, engages women in a complex help-seeking process underpinned by the combination of a multitude of factors that affect one another and act as facilitators and barriers. As women's perception of sexual difficulties is not medical, their husbands are their first source of support. However, seeking professional assistance is specifically less likely to happen when women's problems arise from their husbands' or other contextual factors. Thus, help-seeking for sexual problems is not a

straightforward activity and often requires a consensual decision from the part of the two partners. In addition, since sexual problems are not life threatening, delaying or avoiding this behaviour are common especially that the subject is taboo and women's sexuality is male-centred. However, this behaviour might be triggered by women's perception of the negative consequences of sexual problems on the marital and family life. Thus, it becomes evident that the understanding of help-seeking for sexual problems is also contextual.

The study also indicated that the professionals' assistance is lacking which does not encourage women to seek help. Furthermore, nurses and midwives' roles are not well identified and recognised by all women. These professionals' narratives revealed that they are not prepared to care for women who have sexual concerns and do not feel confident to respond to their needs. The critical finding is that the majority does not consider the field within the remit of their practice. Many of them do not see the priority of patients' sexuality believing that the burden of their illness outweighs their sexual interest. They avoid the subject hoping to deal with by a more competent professional. These narratives expand our understanding of how nurses and midwives perceive their role and reveal how the dominant socio-cultural norms affect their behaviours and attitudes and their commitment as health professionals to provide holistic nursing and midwifery care.

The present study provided a framework that elucidates a holistic understanding of women's sexuality. It also generated context bound information about the factors that

affect nurses' and midwives' roles in sexuality-related care. Being a midwife researcher involved in nursing education grants me the privilege to make suggestions that target nurses and midwives specifically and all professionals generally to proactively work to improve women's sexuality. Thus, the implications of this study are highlighted to inform the education and practice and the recommendations to conduct future research are presented.

10.3. Implications for education

Findings suggest that healthcare professionals do not have an effective role in sexuality care. They lack the knowledge and skills as well as a positive attitude towards women's sexual concerns. Given the interdisciplinarity in delivering holistic care, the professionals whether they are physicians, nurses, midwives, sex therapists or psychologists are required to develop their knowledge and skills to assist women in their sexual concerns and difficulties.

As highlighted by one of the participants, since the professionals are part of society, their sexual socialisation has probably affected their capacity to address sexual issues. As a matter of fact, little attention is accorded to sexuality in professional education. Expanding the curricula to respond to the emerging needs in sexuality care is imperious. Being sexually knowledgeable and comfortable with their sexual self would help women protect themselves against sexually transmitted infections, unwanted pregnancies, sexual violence

and inequalities. Moreover, many health conditions like cardiovascular problems, cancer, mental disorders might have detrimental effects on sexual function which could be alarming for patients.

It is most crucial to expand nurses and midwives' education in terms of helping women see themselves as sexual selves and articulate their sexual needs. More specifically, nurses and midwives educators should develop their capacities to deliver comprehensive sexuality education combining theory, simulation and practice. This will help the students understand the importance of sexuality as an integral part of the individuals' life, challenge their negative attitudes and misconceptions and prepare them to deliver sexuality-related care as an integral part of their role.

In my work place as an assistant Director and lecturer at the University of Balamand - Nursing Programme, sexual health assessment could be added to the 'Physical Assessment' course which is a pre-requisite for all undergraduate clinical nursing courses. This fundamental course prepares the students to complete a comprehensive health assessment and accordingly identify the patients' needs.

As part of its mission, the Nursing Programme at the University of Balamand -a leading academic institution in Lebanon- actively contributes to the lifelong learning of the professional nurses. Thus, the 'Physical Assessment' course is regularly offered by the

Programme to BS nurses working in different healthcare centres in Lebanon. The inclusion of a sexual assessment component in this course will definitely sensitise nurses to integrate sexuality-related care in their daily practice. Being in the process of launching a Master's Programme, the concept of sexuality will be at the core of the curricula.

Being involved in a 'Research Group of Sexual and Reproductive Health' that embraces researchers from the Middle-East and North Africa including Lebanon, gives me the opportunity to disseminate and discuss findings of this study with professionals from the region. Adding to that, I will disseminate findings of this study in different conferences to sensitise the professionals to the importance of their role in sexuality care.

10.4. Implications for practice

Findings of this study have implications for the professionals like physicians, psychologists, sociologists, educators and particularly nurses and midwives to assist individuals, couples and families in developing their sexual literacy. The most important problem that affects women in their sexuality stems from an inappropriate sexual socialisation to understand and develop their sexual self and agency within the inhibiting and gender-based culture.

A comprehensive sexual education should be developed at the level of the society through direct communication, group discussion and seminars. Meaningful information that is culturally sensitive, simple and concise could be delivered through brochures,

pamphlets and audiovisual messages. It would be interesting to create local sites and help-lines led by a multidisciplinary group of professionals to provide information and answer women and couples' questions. Relying on social figures and celebrities may serve to attract public interest, reach underserved populations and raise awareness across different groups in society. Another avenue for women's assistance is the creation of sexual counselling through the implementation of sexual health clinics that are available, accessible and affordable, which is not presently the case in Lebanon. In this endeavour, the place of the community nurse and midwife is particularly acknowledged in view of their interaction with women in their context and family environment.

An international symposium on gerontology will be organised in 2017 by the Nursing programme at the University of Balamand. One session will be dedicated to sexuality and open to the public considering the importance of the topic and its novelty in the Lebanese context. Community seminars could be organised with small groups of women to discuss their concerns and get the opportunity to learn from and support each other. This would also help them find ways to solve their sexual problems which do not necessarily need professional assistance or medical treatment. This was experienced by women in focus group discussions; women were eager in reflecting –and for some of them for the first time– on their sexuality and analysing their sexual concerns. Women who participated in the study felt the need to talk about their sexual life and trust someone who can listen to them and provide them with assistance. This was a kind of therapy for them.

Women have to learn how to negotiate their concerns first and mostly with their partners. In this context, working with the couples to enhance their communication skills and discuss their sexual issues is a must as according to women, this is less likely to happen within their relationships with their husbands. The duality of the relation supposes the reciprocity between the two partners at the level of mind and body; otherwise, the notion of sexual subject and sexual object is permuted based on the circumstances of each 'sexual scenario'. My personal belief is that like women, men too might be victims of misconceptions and stereotypes that impose on them high expectations. Presumably, men may hide their limitations to preserve their powerful masculinity and women inhibit their needs to preserve their innocent femininity. Thus, both of them need the professionals' support.

Advocate for a comprehensive sexual education that initiates boys and girls at their early age to a) understand the different dimensions of sexuality including the physiology, relationships and emotions; b) get aware of their bodies; c) be sensitised to one another needs; and d) develop their sexual self, attitudes and responsibilities in their sexual interactions. Sexual education helps people protect their sexual health and wellbeing. When women are sexually aware, they act upon their needs without intimidation. In Lebanon, sexual education is still languished due to religious powers and traditions despite the many initiatives to improve it. It is mainly offered in the private schools which in their majority are Christian. Yet, the programmes differ from one school to another

and are mainly focused on reproductive health. In addition, sexuality educators need preparation to have an appropriate approach in offering sexology education.

Besides their role in the community, nurses and midwives should introduce sexual health assessment in their clinical practice. They have to communicate with the patients about their sexual issues since the disease may compromise their sexual functioning. They have to collect sexual history that is culturally sensitive and in respect to individuals' perceptions, values and beliefs avoiding discrimination and judgment. More specifically, sexuality is at the core of the midwife's practice as she deals with the couples' reproductive issues and is exposed to their sexual concerns on a daily basis.

Many models are available in the literature to assist nurses and midwives in dealing with patients sexual concerns like the Permission–Limited Information–Specific Suggestions–Intensive Therapy Model (PLISST) (Annon, 1976). This model is commonly used. Upon assessment, nurses or midwives could help the patients or refer them as needed to other professionals.

10.5. Recommendations for future research

10.5.1. Introduction

Many findings open avenues for future enquiries driven by qualitative approaches that would contribute to the conceptualisation of the new view of women's sexuality

considering different age groups and contextual factors. New enquires would also assist professionals to better understand and address individual needs and expectations. The study explored the meaning women attribute to sexuality and sexual problems. Their sexual drive, sexual response, how they achieve orgasm and other erotic facets of their sexuality were not examined by fear of invading women's privacy. Since the research on sexuality is not common, it was difficult to predict if women would talk about the subject. To overcome this difficulty, a vignette was used in the first phase of the study. This gave me more confidence to ask direct questions in successive interviews. So, this study paved the way to inquire about more sensitive research questions in the future about sexuality.

10.5.2. Research on sexuality

Sexual socialisation emerged as a major element of women's perception and experience of sexuality and sexual difficulties in this study. It also affected the messages women transmitted to their children, perpetuating the silence around sexuality. Knowing that children's sexual socialisation is initiated by the parents, women with poor knowledge and skills and negative attitudes towards sexual discourse especially with children of the opposite gender would not be able to assume this responsibility. This raises the urge to understand how the parent-child sexual education is handled; what are the messages transmitted and forbidden; what are the difficulties encountered in their communication about the subject; how their approach varies with respect to boys and girls; what is the role of each parent knowing that the fathers' role was absent in this study; and how

parents approach/conduct might protect or expose children to risky sexual behaviours. It would be also critical to explore the content of the programmes of sexual education at schools and the way they are delivered in light of the new initiatives to improve this aspect of children's education. Questions could also be asked about the impact of the Internet and media messages on the openness of the new generation. Thus, it would be interesting to see how sexuality, affected by globalisation and sociocultural changes, has shifted by comparing individuals of younger and older age groups. Openness also evokes the enquiry about the adolescents' sexual behaviours in view of the high prevalence of sexually transmitted infections and other risky behaviours. Answering these research questions would expand the understanding of different aspects of sexuality.

In a gender-based heterosexuality, the husband is central to women's sexual satisfaction and difficulties as it was reported in this study. Exploring men's understanding of their own and women's sexuality in terms of perceptions, outlooks, expectations, behaviours, satisfaction and difficulties should not be ignored. How sexuality is shaped within the relationship and in consideration of overall life and marital satisfaction is also an avenue to get insights into women's sexuality. This might be enriched by exploring the couples' views about the topic. Women of this study claimed their need for intimacy and affection in their sexual relationship. Yet, they highlighted their sacrificing role to please their husbands urgent needs, avoid their intimidation and preserve marital unity and family life. Engaging in sex dutifully to gain agency and faking orgasms were commonly reported,

hence, deserving further exploration. Other points of enquiry might relate to sexual orientation and premarital sex given women's emancipation and their rights to express their sexuality the way they feel comfortable. This was not apparent in this study, since all those who volunteered to the interviews were seemingly heterosexual and the majority were married and reflected on their sexuality as part of marital life.

This study was conducted with middle-aged women as this transition period that is characterised by the occurrence of menopause, induces physiologic and psychosocial changes that might alter their sexuality. Unexpectedly, sexual symptoms commonly associated with menopause were not of great importance for women and were not bothersome, although some women were afraid of the effect of the cessation of menses on their body image and femininity. Women from different cultures and backgrounds would have differing views of menopause that may influence their sexual self at the middle age and beyond. This is crucial in view of the stereotypes and misconceptions that are inherent to sexuality and ageing. Thus, reporting on the way Lebanese women may look at menopause from a qualitative perspective would draw attention to the multidimensional aspects of this important event in their lives.

10.5.3. Research on sexual difficulties

Women's sexual difficulties constitute another salient finding of this study. On one hand, it contradicts the medical classification of sexual dysfunction as discussed earlier and calls

for more qualitative enquiries to further validate the 'New View' and DSM-V update of sexual difficulties that are still under-explored. On the other, seeing these experiences as mainly male-centred would raise the question about the interrelation of physical, relational and psychosocial factors and the implications of women's sexual self in determining these difficulties. Researching these different aspects would provide more in-depth information about the subject affording every aspect its importance. It would also contribute to avoiding sexual medicalisation and inciting professionals to look at sexual difficulties as contextually bound. Additionally, exploring men's views and experiences about their sexual problems is important to demystify the myths about their sexuality which is perceived as purely physical and their problems as easily solved by the blue pill.

10.5.4. Research on help-seeking for sexual problems

Given the scarcity of research on help-seeking for sexual problems, testing and validating the theoretical framework that was elaborated and published within this PhD study (Azar, Bradbury-Jones and Kroll, 2013) would provide more insights about the process that may trigger or hamper this behaviour. This understanding is crucial to know why people tend to avoid help-seeking for sexual problems. Thus, men's resistance as reported by women of this study to admit and disclose their sexual problems would stimulate the researchers to inquire about the way help-seeking is shaped among men focusing on the perception of sexual problems and other contextual factors.

In addition, conducting research with varied samples of men and women of different age groups and backgrounds will be useful to get more insights about the subject, compare help-seeking in relation to gender variation and report on the outcomes of this behaviour. This brings to mind the investigation about the health professionals', especially nurses and midwives, perception and attitude about sexuality-related care as women did not seem to be satisfied of their approach with them. These professionals' resistance and lack of competence to address the subject was also apparent in this study. Informed by findings, a quantitative research was conducted with a sample of nurses and midwives including students and professionals to identify their attitudes towards patients' sexual health assessment and to suggest ideas to improve their practice.

10.6. Strengths of the study

The value of this study in enriching the body of knowledge about women's sexuality is undeniable particularly in Lebanon where little is known about women's sexuality. Researching a very sensitive topic especially among women at their middle-age constitutes a considerable contribution to shed light on a topic that has been up until now taboo and seldom tackled. The in-depth interviews and focus-group discussions gave women the occasion to voice their concerns, articulate their needs and construct their sexuality from their own perspectives rather than adhering to clichés. The exploration of sexuality and sexual difficulties adds to the feminist and social science literature about the subject. Findings support these researchers' stance to understand women's sexuality using a

naturalistic approach that captures the differing conceptualisations and experiences as contextually bound. Furthermore, findings contest the inaccurate prevalence rates of sexual problems that widely prevail in the literature. Findings also oppose the persuasive blurring promises of pharmaceutical companies advocating for marvellous drugs to ensure romance. Although many women experienced sexual difficulties, they perceived them as rather contextual and mainly related to their sexual socialisation and husbands' problems. Thus, findings can serve to promote our perceptions, attitudes and behaviours towards sexuality giving credit to middle-aged Lebanese women who voiced their sexuality contributing therefore to the enrichment of the body of knowledge.

Using a qualitative approach to explore the patterns of help-seeking for sexual difficulties of the middle-aged women and building on a comprehensive literature review to frame help-seeking in a theoretical model (Azar, Bradbury-Jones and Kroll, 2013) made a unique contribution to the understanding of this concept. Additionally, nurses' and midwives' feedback concerning their role also contributed to shed light on a subject that was not previously explored in Lebanon despite its implication on sexuality. The different concepts explored emerged inductively in a logical sequence where every research step informed the other and provided a comprehensive framework for women's sexuality and nurses and midwives' perception of their role in sexuality-related care. In addition, the use of a qualitative design generated a multitude of enquiries that ought to be explored as suggested above. The use of a varied sample combining individual and focus group

interviews ensured rigour for the study. Although Lebanon is unique in its sociocultural identity and structure, the transferability of findings that emerged from this study to other contexts – particularly those with similar characteristic– might be considered.

10.7. Limitations of the study

In parallel, some limitations are acknowledged. The study relies on a sample of middle-aged women who identified themselves as heterosexual and the majority was married. So, other aspects of women's sexuality including sexual orientation and sex outside marriage would have been differently perceived. In view of the complexity of sexuality, the recruitment process was difficult as many eligible women refused to participate in the study. I had to spend more time in the field to reach the purpose sample. Some participants of the different phases of the study found difficulties in reflecting on the subject and may not have expressed themselves sufficiently. While the use of a vignette in the first interviews of the first phase of the study was necessary to break the taboo around sexuality, it might have induced hypothetical data. Nevertheless, the vignette served to prompt women to talk and then, they reflected on their own experiences. In addition, the careful attention accorded to women, the warm and private environment of the interviews and the relevant probing technique helped me overcome this limitation. The sample was based on a group of participants who volunteered to be interviewed. It is arguable that those who participated were interested by the topic and had the need to reflect on their concerns. Yet, the participants' willingness to talk particularly when

addressing a sensitive topic is essential in qualitative enquiries to provide rich data. Another limitation was the considerable potential for language and nuanced cultural complexities and understandings to be 'lost in translation' from Arabic to English. However, the meticulous translation processes and the comparison of data in the two languages by Lebanese and non-Lebanese researchers created confidence in the robustness and accuracy of the meaning of the participants' narratives in English. Many of the above mentioned limitations could be addressed in future research.

10.8. Concluding reflections

And the dream comes true. It was in the hallway of my workplace at the Faculty of Health Sciences, University of Balamand in Beirut that I decided to pursue a PhD at the University of Dundee.

I started my study with a lot of determination and the certainty of conquering all obstacles, namely balancing my workload and personal life, with the PhD degree requirements. Nothing was more enjoyable for me than getting through the different steps of my qualitative study. I was fulfilled by acquiring the know-how for critical inquiry, logical reflection, authentic conceptualisation and robust persuasion. The PhD process was a long learning journey that strongly involved and asserted my 'I's'. To mention but a few, I was motivated by my passion, perseverance, patience and perfectionism.

Now, as I stand at the point of culmination of my thesis, and reflect back on the progression of my work, I find myself re-questioning certain issues. I ask myself the extent to which I have:

1. Comprehensively answered the research questions of the study?
2. Reflected the reality of women's sexuality and conveyed their thoughts, feelings, experiences and concerns?
3. Triggered some women's anxieties over their sexuality or invaded their privacy
4. Contributed to the literature specifically in our region and made a step towards encouraging women's sexual rights and self-affirmation?

Knowing that qualitative studies are subject to different interpretations and that there are different ways of making sense of the world, I believe that I have used appropriate methods to portray women's views. At the start of the study, the main aim was to understand the pathways of help-seeking for sexual problems. Yet, upon entry into the field, new research questions emerged. Accordingly, and after many discussions and reflections with my supervisors, the decision was made to follow the emerging pathways of the study in a way that more authentically reflects women's reality. Thus, although help-seeking behaviour remained a concern, women's understanding of sexuality and sexual problems became the main focus of the investigation. Not only that but, informed

by findings, I decided to also explore how nurses and midwives perceive their role in sexuality-related care aiming at supporting them to have a more effective contribution in the promotion of sexuality and sexual health. I am confident that using inductive reasoning and the emerging design of qualitative research, focusing on the research process and outcomes, allowed me to accurately answer my research questions, develop meanings and draw conclusions about women's sexuality grounded in the data.

A multiphase study was conducted relying on different methods of data collection and heterogeneous samples with one phase endorsing the other informed by women's accounts and reflections on the different aspects of their sexuality, providing intense and dense data. This provides the answer to my second concern as women reflected on their sexuality as an embedded social reality. They interpreted their sexual life according to their personal, relational and sociocultural context, highlighting their thoughts, feelings and experiences. The qualitative study approach satisfied my interest in gaining their insights by questioning and probing the what, how and why of their stories.

Considering my third concern, it was reassuring to find that the majority of the participants acknowledged benefitting from the discussion and feeling empowered by the freedom to talk about their sexuality and sexual concerns. This was a unique opportunity for them to break the taboo around sexual disclosure; get a sense of their sexual self; relieve the burden of their sexual distress; and increase their awareness about sexual

problems and the possibility of referring to a professional for help. Many women were enthusiastic to know that sexuality-related research and care is beginning to emerge. Although the study had advantages and engendered no harm to the participants, I do not deny that many of them lacked spontaneity and were reluctant to reveal their thoughts and share their experiences despite my attempts to be unobtrusive, understanding and supportive.

As for my last concern, I would claim that the study contributed to sexual knowledge specifically in our region and hopefully made a step forward towards women's sexual rights and self-affirmation. So far, I have published two papers and have participated in a number of oral presentations based on the results of this study. I am committed to disseminate other aspects of the study findings through more publications and involvements in seminars, conferences and sexual research groups.

At the end, I argue that the construction of sexuality does not happen in a vacuum. Sexuality is the result of a developmental process that is affected by all aspects of the individuals' life from childhood, till adulthood and elderly. This asserts the need to raise awareness at the level of the policy-makers, professionals, children, men and women about sexuality and give priority to this important phenomenon of our life. Sexuality could not be the responsibility of one party and the focus of only a particular period of the individuals' lifespan. Sexuality is dynamic; it changes and transforms and requires

continuous alertness and attention. In other words, women could not negotiate their sexuality if they are not aware about their body, are not empowered to voice their concerns and are not heard and supported to meet their needs and realise their sexual self. I believe that men's and women's sexuality are interdependent and could not be experienced and expressed in 'thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles, and relationships' without the full consideration of one another's biopsychosocial and cultural context. To conclude, I would say that women cannot wait for others to let them enjoy their sexuality. They have to steer themselves the direction they want for their sexuality. Their assertiveness would lead their way and move their sexuality from the muteness to self-confirmation.

My PhD experience is nearing completion. It has been an enriching learning experience and a special time in my life. I hope that it will serve as a foundation for future research and collaborations as I transition into my post-doctoral career.

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Appendix One

Example of data charting of the scoping review about help-seeking behaviour for sexual problems

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Aisuodionoe-Shadrach, 2012 Abuja, Nigeria	To evaluate the perceptions of sexual health and understanding of female sexual dysfunction [FSD] in a group of adult females attending an FSD seminar	Quantitative cross-sectional	50 Female hospital workers, 27 to 49 y	Self-administered questionnaire: Sociodemographic data [SDD], sexual health/activity, status of menopause, if genital mutilation, SD; if willing to discuss with a trained sexual health physician	FSD: 28 women with FSD, lack of desire or interest in sex. Help-seeking [HS]: Barriers: Poor perception about FSD and treatment Facilitators: comfort in discussing FSD if there is access to an expert	Limitations: Questions not pretested; no varied sample; distress with FSD not searched. Recommendations: more and long-term outcome studies on assessment and management of FSD; population-based studies
Bagherzadeh et al., 2010 Iran	To detect the prevalence and risk factors of FSD and related factors to non treatment in Bushehrian women	Quantitative cross-sectional	1054 married women without health problem, 18-59y [36±2]; random sample; rural and urban health centres; Clustered by age and health centre	SDD, Female Sexual Function Index [FSFI], reasons for not consulting a Dr	FSD: 37.7%; 8.3% severe; FSD varies with SDD. HS: 9.2% visited a Dr. Barriers: shame; no access to/not aware about services; no trust in/need for treatment; husbands' pressure; marital secret; poverty	Strengths: representative sample; taboo topic Limitations: clinical sample, privacy; not enough variation Recommendations: Training HPs; screening for FSD; having dialogue with women. More studies to understand HS

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Berman et al., 2003 Website/ Caucasian (88%)	To explore the patient experience of seeking help for a sexual function complaint from their physician	Quantitative cross-sectional	Web-based. A volunteer sample of 3,807 women of 18 to > 75 y	SDD; help-seeking scale and feeling associated with their experience scale. Piloted	FSD: 46-77% HS: 42% from their gynaecologist [gyn]; 54% would like to do so. Barriers: discomfort; negative perception about SD and HS and Drs' negative attitude Facilitators: Drs' willingness and interest; positive feelings about HS	Strengths: Web-based survey is efficient and confidential; identifying the factors affecting HS. Limitations: Lack of variety Recommendations: more studies on HS; training Drs; explore non-heterosexuals.
Bogart et al., 2011 USA	To examine the prevalence and correlates of general and bladder pain syndrome/ interstitial cystitis (BPS/IC)-specific FSD	Household survey	1469 women Data on those with a current sexual partner (985, 74.6%). $M=43.6 \pm 16.7$ y	BPS/IC-specific scale and general SD, bladder symptom severity, general physical health, depression, medical seeking, and SDD	SD: 88% associated with BPS/IC/SDD/health. HS: One quarter sought medical help; 4% SD completely resolved and 26% partly resolved	Strengths: Probability community sample Recommendations: Clinicians' awareness, interdisciplinary sexual health care, cognitive-behavioural therapy

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Brock et al., 2006 Canada This study is part of the Global Study of Sexual Attitudes and Behaviours (GSSAB) conducted in 29 countries	To study sexual activity, the prevalence of sexual difficulties and related help- seeking behaviours [HSB], among mature adults in Canada	Quantitative cross-sectional survey	Random-digit household dialling sampling design; 40 - 80 y women and men sampled in approximately equal numbers (500 men and 507 women) aged between 40 and 80 y	Computer-assisted telephone interviews (CATIs) Questionnaire on: SDD, general health, relationships and sexual behaviours, beliefs and attitudes, SD and if HS	SD: 24-30%. HS Barriers: perception of SD and HS. Negative attitude towards the Dr: few Drs ask women about their sexuality; Dr may not feel at ease talking about sex	Strengths: population- level data; highlighting sexual interest and activity among the middle aged and older adults. Limitation: Low response rate; self reported measures and many are based on one single item

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Buvet et al. 2009 France and southern (Spain, Italy) and northern (Austria, Belgium, Germany, Sweden, UK) European countries. (GSSAB)	To report the sexual activity, prevalence of sexual problems and related HSB among adults in France and compare findings with those seen in the rest of Europe	Quantitative cross-sectional survey	Random-digit household dialling sampling design. 40 - 80 y women and men sampled in approximately equal numbers (750 men and 750 women) completed the survey, response rate of 23.8%	Computer-assisted telephone interviews (CATIs) GSSAB Questionnaire	SD: 9.6-20.9%; values about twice as high as those reported in the rest of Europe. HS: 58.2% had not sought any help; 39.5% talked to a Dr; mainly from the partner. Barriers: attitude and beliefs about SD, discomfort, Dr" attitude, no-affordability and unaware of care Facilitators: being dissatisfied and lubrication difficulties	Strengths: asserting old people sexuality, Drs' role in HS. Limitations: Challenges related to an accurate translation of the questionnaire in multiple languages; low response rate; not truly representative; self reported measures and many are based on one single item
Catania et al., 1990 California Bay Area	To identify the type of HS for sexual problems [SP] and associated factors	Quantitative cross-sectional	Community convenience sample 503; 91% women, 18-59 y; M=31.8 \pm 9.6 y. 97% heterosexual	Self-completed questionnaire: SSD, physical or psychological therapy, Personal assessment of sexual problems, sexual distress, HS	SP: 43%; 23% had and their partner SP; SP was associated with sexual distress. HS: 20 % did not seek any help; few sought formal help; self help; partners mainly; Barriers: income	Strengths: The first studies on HS for SP. Limitations: Convenience sample limiting the generalisability; comparison hindered by the scarcity of studies on the topic

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Danielsson et al., 2003 Sweden	To investigate the prevalence of dyspareunia in women, the rate of recovery and the inclination to seek medical care	Quantitative cross-sectional	3,017 women of 20–60 y; community-based convenient sample divided in different age groups	Questionnaire about dyspareunia	SP: dyspareunia 9 times higher among younger women. HS: 39% referred to a Dr or midwife or both to relieve discomfort; many recovered spontaneously	Strengths: The first in Sweden; women not included based on their sexual activities; sample representative. Recommendations: qualitative studies; help; knowledge on HS
Donaldson and Meana, 2011 Las Vegas USA	To explore the experience of dyspareunia symptoms in young women so as to model its cognitive, emotional, behavioural and help-seeking trajectory	Qualitative grounded theory	14 young women reporting on pain with intercourse recruited from psychology undergraduate classes and advertisement	Semistructured interviews on cognitions and emotions related to dyspareunia. Initially screened by the Female Sexual Functioning Index. Analysis by the two authors separately	Cognitive–behavioral model of dyspareunia. HS: minority sought treatment; five reported to Drs and felt dismissed Barriers: Faith in the spontaneous remission; lack of confidence in a medical solution; not trusting professionals relational; fear of stigma	Strengths: multifactorial model on dyspareunia and the trajectory of HS. Limitations: possibility of sampling bias; diagnosis with FSFI and not by Dr. Recommendations: multidisciplinary, pro-activity, self-efficacy to manage the problem public awareness

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Dunn et al., 1998 England	To assess the prevalence of sexual problems and use and need for help-seeking	Quantitative cross-sectional	Sample of 789 English men and 979 women of 18–75y, 75% of whom were married. Mean age of women 48 y.	Piloted questionnaire on SP	SP: 34% of men and 41 of women. HS: 39% of women reported they would seek help but only 4% did. They prefer to seek help from female HP	Strengths: Representative sample Limitations: Clinical sample; possibility of false response Recommendations: HPs' pro-activeness in sexual health; public awareness
Elnashar et al., 2007 Egypt	To assess the prevalence and associated factors of female sexual dysfunction (FSD) in Lower Egypt.	Quantitative cross-sectional	Systematic Clinic/ hospital-based survey 1000 married women of 16–49 y. High response rate 93.6%	Questionnaire on FSD and associated risk factors and physical examination when allowed and SDD.	SD: 69% and 23% not distressed. SDD and husbands SP associated with SD. HS: 7% medical treatment; no improvement in 58.7% of women	Strengths: exploring an under-researched topic; representative sample. Limitations: clinical sample. Recommendation: Studies on SD, Drs'; competency; training

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Fitter et al., 2009 North England	To explore the factors that influence individuals and couples to discuss sexual and/or relationship difficulties with a primary HP	Qualitative	Purposive sample with two men and three women of 35-45 y	Semistructured interview Thematic analysis using Ritchie and Spencer (1994) and Braun and Clarke (2006) methods; data conducted by two members	Factors affecting help-seeking: Relationship characteristics; Context; Perception of the problem; Professional approachability'; Awareness of services; and Openness	Strengths: use of Vogel et al (2006) model; Identifying relationship difficulties in HS Limitations: Clinically based sample; characteristics not specified; small sample 5 out of 39 accepted to participate
Gott & Hinchliff 2003 UK	To identify barriers experienced by older people in seeking treatment for sexual problems [SP]	Grounded theory	Purposive sample by gender and age 50–92y. 22 women and 23 men	Semi-structured individual interviews; ethical approval; Framework analysis [Ritchie and Spencer, 1994]; double coding and checking by the two researchers of the study	SP: 25 participants. HS: Six; General practitioner [GP]; Barriers: characteristics and attitude of the GP; Participants' perception of the severity of SP; Psychosocial factors; Lack of knowledge about services and lack of appropriate services.	Strengths: Varied sample Limitations: Clinical sample; heterosexual; some hypothetical findings Recommendations: GPs proactiveness in raising sexual health issues to meet the individuals' needs

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Gott et al., 2004 Sheffield	To identify barriers by GPs and practice nurses that stall discussion of sexual health issues in primary care and explore strategies to improve communication in this area	Qualitative	22 GPs [13 male and 9 female] of 34-57 y and 35 female practice nurses of 32-60 y recruited from diverse clinical practices	Semi-structured interviews; consensus on analysis between researchers; analysis with exchange/shared understanding and interpretation of the meanings of data	The role of primary care within sexual health management; The role of sexual health in medical and nursing care; 'The can of worms'; Primary care priorities; Barriers to talking about sexual issues with particular patient groups; Overcoming barriers	Strengths: Rich findings. Limitations: participation rates low; sample drawn from only one UK city. Recommendations: Training on sexual health information and communication
Hinchliff & Gott, 2011 Area not specified	To explore patient help-seeking and physician-patient interactions regarding sexual concerns in mid-later life	Narrative literature review 1999-2011	Men and women ≥ 50 y; any sexual orientation, help-seeking and including doctors	25 articles; 22 studies with patients; 3 sampled doctors; 3 qualitative and one mixed methods	HS: Tendency to not SH Barriers: perception of SP and HS. Negative perception of Drs' role; no sexual counsellors HPs: Drs' reluctance and lack of preparation. Facilitators: lubrication problems; sexual beliefs [not satisfied; sex vital; Dr should routinely ask]; being asked about the topic	Limitations: only English language; 2 databases; patient-Dr interactions. Recommendations: Not neglecting sexual well-being of mid-later age groups; meeting training and developmental needs of HPs

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Julliard et al., 2008 USA	To identify barriers to disclosure of medical information	Grounded theory	28 Latina women living in Brooklyn 18-40 y	In-depth interview and SDD; Authors consensus on the coding and themes	HS: General practitioner Barriers: Physician- patient relationship; language barriers' time constraints; GP age & sex; culture; sensitive issues (sexual the most sensitive)	Limitations: Lack of variety in sexual orientation; interviews not recorded and transcribed verbatim. Recommendations: Research on disclosure. Build culturally sensitive relation with patients
Kadri et al., 2002 Morocco	To determine the prevalence of sexual dysfunction in women.	Quantitative cross-sectional	728 women of 20 and older, M = 36.76 y. Representative randomly selected sample; sample size calculation	Questionnaire: SDD, sexual dysfunction using DSM-IV criteria	SD: 26.6% affected by SDD. HS: 17% from HPs [gyn] and traditional healers Facilitators: Willingness to have a satisfying sexual life; concern about normality; partner's pressure	Strengths: Psychosocial attributes to HS. Limitations: Neglect of non-heterosexual and engaged; broad age group; no discussion of data related to HS. Recommendations: Training the HPs

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Laumann et al., 2009 USA This study is part of (GSSAB)	To study sexual activity, the prevalence of sexual dysfunction and related HSB among mature adults in the United States of America	Quantitative cross-sectional survey	Random-digit dialled sampling design; 742Men and 749 women, 40-80 y	Computer-assisted telephone interviews. GSSAB Questionnaire	SP: 12.7-33.2 % HS: 43.9% did not take any action. Source: 16.1% Dr; 79.7% no help from a HP; help from the partner mainly Barriers: Sexual perception and attitude, HPs' attitude and behaviours, lack of resources. Facilitators: Age group 40-49 y, type of SP.	Strengths: large cross-national population sample; common method of data collection; privacy Limitations: Response rate of 9.0%. Recommendations: education of patients and HPs to increase awareness and overcome barriers
Magnan et al., 2005 USA	To describe attitudes and beliefs about sexuality that might keep nurses from caring of to patient sexuality in their practice and the related factors	Descriptive correlational	A convenience sample of 148 nurses [M=41 y, SD=9.98] working in selected inpatient units and outpatient clinics	Sexuality Attitudes and Beliefs Survey SABS instrument and demographic questionnaire	Barriers: not believing that patients expect nurses to ask about sexual concerns; contradictory thoughts about patients' need for sexual discussion; lack of time; lack of comfort; No association of SABS score with SDD but with type of patient	Strengths: Identifying the gaps in nursing practice in relation to sexual health. Limitations: convenience and small sample chosen from only one area. Recommendations: training; more research in the field

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Magnan and Reynolds, 2006 USA	To examine the barriers to addressing patient sexuality across areas of specialisation	Descriptive correlational	A convenience sample of 302 nurses [M= 43.12 y, SD= 9.82] recruited from a Midwestern medical centre	Sexuality Attitudes and Beliefs Survey SABS instrument and demographic questionnaire	SABS scores had varied association with SDD. Most common barriers: Nurses' perceptions that patients (do not) expect nurses to ask about their sexuality concerns	Limitations: convenience and small sample. Recommendations: Promote nurses' role; research on patients expectations about nurses' role
Maserejian et al., 2010 USA	To investigate treatment seeking and utilization of women diagnosed with hypoactive sexual desire disorder(HSDD)	Quantitative cross-sectional	724 clinically diagnosed women with HSDD, Premenopausal: average age 36.2y [SD] 8.8. Postmenopausal 55.7 y [SD 7.2]	Self-administered questionnaire and clinician's medical history [SDD, relationship, and medical data]; past and current HSB, motivators and barriers	HS: 388 from HPs. 64% received treatment [lubricant and creams]; partner and Internet Barriers: perception about the SP and HS, lack of resources. Facilitators: personal and relational	Strengths: identifying key factors of HSB. Limitations: Focus on medical classification and treatment of FSD, limited to 3 months; not representative sample Recommendations: Public awareness on HS

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
<i>Mathieu et al., 2011</i>	<i>To thoroughly analyse the literature about the knowledge, attitudes and experiences of nursing staff about sexuality in institutionalised elderly</i>	<i>Literature review 1980-2010</i>	<i>Search strategy Different databases</i>	<i>Quantitative and qualitative studies</i>	<i>Positive attitudes toward aged sexuality contrasted with many ageist myths and stereotypes; lack of privacy which is typical of a nursing home environment Methodological critique of the studies</i>	<i>Limitations: disproportional number of quantitative and qualitative studies; ambiguity concerning the effects of some SDD on knowledge and attitudes. Recommendations: Develop an institutional ethics policy on aged sexuality; tolerate residents' sexual behaviour</i>
<i>Mercer et al., 2003 Britain</i>	<i>To estimate the prevalence of sexual function and problems in the general population</i>	<i>National survey</i>	<i>Stratified probability sample of men and women of 16-44y. Response rate 65.4%</i>	<i>Computer assisted self interview: Sexual lifestyles and attitudes; Sexual dysfunction as per ICD-10</i>	<i>SD: 53.8% of women; 62.4% of them avoided sex because of their SD. HS: 21.0% mainly from the GP</i>	<i>Limitations: Descriptive study and results not discussed in relation to other characteristics. Recommendations: Education and public awareness</i>

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Mitchell et al., 2009 Britain	To identify factors associated with reporting lack of interest in sex among women and to explore if these factors differ according to whether or not help was sought	Quantitative cross-sectional	Multistage probability cluster sample of 12110 men and women of 16-44 y. 6,942 women	Computer-assisted personal interviews on behavioural, attitudinal and SDD	SD: 10.7% of women HS: 27.9% mainly from the GP. HS associated with marital status and the perception of health; SD and HS associated with talk about sexual issues, experience of first intercourse, interest for sex	Strengths: Representative sample and high response rate (65%). Limitations: age 44max; broad range of topics covered by single items; HS is not an attribute to sexual distress; other factors should be considered
Moreira et al., 2005a Global study of 29 countries GSSAB	To describe HSB with regard to six specific sexual problems among men and women aged 40–80 years in 29 countries, representing most of the regions of the world	Quantitative cross-sectional	Random-digit-dialling 27,500 men and women aged 40–80 years, more or less equally divided. No particular criterion to select the 29 countries, but the convenience for the logistics of the survey	Telephone interview, door-to-door protocol or an intercept protocol depending on every region of the world. GSSAB questionnaire	SP: 49% of women [17-32%] HS: 78% sought no help 18.8% medical HS. HS varied by region. Talk to partner mainly Facilitators and Barriers: SDD, perception SP and HS, Professionals' approach	Strengths: Cross-cultural. Few studies on HS. Limitations: low response rate [LRR]; self reported measures and many are based on one single item. Instruments lacked sensitivity in some countries Recommendations: Awareness on sexual health and HS among clinicians and patients

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Moreira et al., 2005b Brazil (GSSAB)	To report data on sexual activity, the prevalence of sexual problems and related HSB among men and women in the Brazilian cohort of the GSSAB	Quantitative cross-sectional	A computer-assisted telephone interview survey, using random-digit dialling	Telephone interview with 1,199 individuals (471 men and 728 women), conducted by interviewers of the same gender. GSSAB questionnaire	SP: 18-23.4% HS: 29.7% sought no help; 53.1% sought no help from a HP Source: 44% Dr. HS predicted by high income, lubrication difficulty, being asked by a doctor about possible sexual difficulties during a routine visit	Strengths: comparisons with different countries; common method of data collection. Limitation: SD may be under-reported, LRR 18.4% but justified by the authors. Recommendations: Improving care availability
Moreira et al., 2005c Spain and other Southern [SE] (France, Italy) and Northern (Austria, Belgium, Germany, Sweden, UK) European [NE] countries (GSSAB)	To study sexual activity, the prevalence of SD and related HSB among mature adults in Spain	Quantitative cross-sectional	Random-digit dialling sampling design; 750 men and 750 women; response rate of 23%	Computer-assisted telephone interviews (CATIs) GSSAB Questionnaires	SP: 10.7-36.0%; Spain the highest. HS: 38.9% no HS. 18.6% talked to a Dr (lower than in the rest of the SE but similar to NE); 80.2% no help from a HP; 51.5% talked to the partner. Barriers: HS varies with age, belief about SP and HPs; lack of access to or affordability of care. Facilitators: lubrication difficulties	Strengths: first study comparing with other European regions, large cross-national sample and common method of data collection. Limitations: LRR Recommendations: Empower women, train physicians to broach the topic

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Moreira et al., 2005d Germany and other NE (Austria, Belgium, Sweden, United Kingdom) and SE (France, Italy, Spain) countries (GSSAB)	To report the sexual activity, the prevalence of SP and related HSB among subjects in Germany	Survey	Random-digit dialling sampling design; 40 - 80 y 750 women and 750 men	Computer-assisted telephone interviews (CATIs) GSSAB Questionnaires	SP: 5.3 - 17.6 %, the lowest in Germany. HS: 38.8% no HS; 15.2% talked to a Dr, 83.0% no HS from a HP; values slightly lower than in rest of Europe; 47.1% talk to partner. Facilitators: lubrication difficulties Barriers: perception of SP, lack of access to or affordability of medical care, doctors' approach	Strengths: the same as above Limitations: LRR 17.4% Recommendations: Encourage physicians to be more proactive
Moreira et al., 2006 Korea (GSSAB)	To study the prevalence of SP and HS in Korea and to compare the results with those obtained in other Southeast Asian [SA] and East Asian [EA] countries	Quantitative cross-sectional study	Random-digit dialling sampling design. 1,200 individuals (600 men and 600 women) aged 40–80 y. Response rate of 32.5%	Arbitrarily selected and contacted in public areas. GSSAB Questionnaires	SP: 26.9%-36.5%; HS: 70.4% no HS; in Korea and EA and less common in SA; 18% talk to the partner. 96.8% no HS from HP 2% talked to a Dr (lowest in Korea). Barriers: HS varies with age, belief about SP and HPs. Facilitators: Drs' way and inquiry about SP	Strengths: First study to report population-level data and allow comparison between Korea and other regions of Asia. Limitations: LRR Recommendations: Train physicians to broach the topic, educational programs for women and HPs.

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Moreira et al., 2008a Australia (GSSAB)	To report on sexual activity, the prevalence of sexual difficulties and related HSB among participants in Australia	Quantitative cross-sectional	Computer-Assisted Telephone Interview (CATI) 1500 individuals, (750 women and 750 men), 40 - 80 y	Standardised GSSAB Questionnaires	SP: 25-33% HS: 77% sought no help. 18.5% talked to a physician; mainly talked to the husband	Strengths: population-level data. Interest in sexual activity at middle and old age. Contrast between the high prevalence of sexual difficulties and low HS.
Moreira et al., 2008b UK and other Northern (Austria, Belgium, Germany, Sweden) and Southern (France, Italy, Spain) European countries (GSSAB)	To study sexual activity, the prevalence of sexual dysfunction, and related HSB patterns among middle-aged and older people in the UK and Europe	Quantitative cross-sectional	Random-digit dialling sampling design. 1500 individuals, (750 women and 750 men), 40 - 80 y Response rate 17%	Computer-assisted telephone interviews GSSAB Questionnaires	SP: 23.6-33.7%. HS: 57.7% took no action, 16.7% talked to a Dr, 82.3% referred to a HP; 32.5% talk to their partner. Compared with the other European regions, women in the UK were most likely to take no action for SP. Facilitators: college education, lubrication difficulties beliefs about sex and dissatisfaction. Barriers: perception of SP, lack of access to or affordability of care	Strengths: Comparison with other European regions, large cross-national population sample and use of a common method of data collection. Limitations: LRR Recommendation: Train physicians to broach the topic

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Nazareth et al., 2003 London	To assess the prevalence of ICD-10 diagnosed SD, the associations between sexual and psychological problems, and HS for SP	Quantitative cross-sectional	Convenient sample from 13 general practices in London. Participants 1065 women and 447 men of 18-75y attending general practice	Questionnaire on sexual function, orientation, behaviour, psychological problems, lifestyle, quality of life, HS and SDD	SP: 13-40%. Women with a diagnosis were more distressed than those without FSD. Predictors included age, poor health and sexual dissatisfaction. HS: 22% sought help from the general practitioner	Strengths: first study with people attending general practitioners; distress with SP; not limited to sexually active people. Limitations: lack of variability in sampling. Recommendations: physicians' training
Nicolosi et al., 2005 Asian countries: China, Taiwan, South Korea, Japan, Thailand, Singapore, Malaysia, Indonesia, Philippines (GSSAB)	To study sexual activity, the prevalence of sexual dysfunction and related HSB among middle-aged and elderly people in Asia	Quantitative cross-sectional	A random population survey, urban residents, 40-80 years, 3350 men 3350 women	GSSAB Questionnaires mailed to a sample drawn from telephone directories	SP: more than 30% of women had at least one sexual dysfunction [SD]. HS: 45% did seek no help and only 21% sought medical care [Dr]. Barriers: perception about the problem, lack of resources	Strengths: Population survey; comparison between countries and men and women. Limitations: Challenges related to the accuracy of the translated instrument in multiple languages; rural areas not included; low response rate [27%]. Recommendations: Further research; social, educational and economic support

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Nicolosi et al., 2006a Sweden, UK, Belgium, Germany, Austria, France, Spain, Italy. (GSSAB)	To study the sexual activity and the prevalence of sexual dysfunctions and related HSB among people in Europe	Quantitative cross-sectional	Random-digit dialling sampling design; 10 000 individuals (4,977 men and 5,023 women), 40-80 y	Computer-assisted telephone interviews (CATI) GSSAB Questionnaires	SD: 6-18% varying within countries HS: 36% sought no help, 55% used family or social support, 31% sought medical care and 19% got information in the media; 74% did not consult a physician Barriers: perception of SP; lack of affordability of medical care	Strengths: first study to report population-based European data; cross-country comparisons, cross-national sample; common method of data collection. Limitations: LRR, 18.4%
Nicolosi et al., 2006b USA, Canada, UK, Australia, and New Zealand. (GSSAB)	To investigate sexual behaviour, sexual dysfunction, and related HSB in five Anglophone countries	Quantitative cross-sectional	Random-digit dialling sampling design Telephone survey 5,998 individuals; (2,992 men and 3,006 women), 40-80 y	Telephone interviews Questionnaire on: SDD, health, relationships, sexual behaviours, attitudes and beliefs. SP and if HS	SP: 5-36% HS: 36% did not seek help, 55% used family or social support, 32% sought medical care, 19% got information from the media. Barriers: perception of SP, lack of affordability of medical care	Strengths: first population-level study from different Anglophone countries Limitations: LRR, 13%. Recommendations: sexual health education

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Nusbaum et al., 2004 Madigan Army Medical Center, Tacoma, Washington	To compare prevalence and type of sexual concerns and interest in and experience with discussing these concerns with physicians for women 65 and older	Cross-sectional survey	Primary care practice; 964 women; 163 (17%) ≥ 65y. Piloted. Younger group 40 ± 13.5 and older group 70 ± 4.0	Self-reported questionnaire on sexual concerns and interest in and experience with discussing these concerns with their physicians and SDD	SP: All women ≥ 65y reported ≥ 1 sexual concerns. HS: 68% never discussed the topic during a medical visit. Facilitators and barriers: Older women less likely than younger women to raise the topic; Drs' approach affects the discussion	Strengths: identifying Dr's limitations. Limitations: lack of generalisability Recommendations: preparing primary care physicians to address sexual issues
Papaharitou et al., 2005 Greece	To report female sexual problems and concerns of women calling a help-line, and to evaluate HSB regarding sexual matters	Quantitative descriptive	Convenience sample; 3,523 calls made by women, 2,287 full forms were analysed; 16-82y [M= 35.98 ± 12.24]	Telephone interview on SP, SDD, health problems and HS.	SP: own 46.6% and partners 45.1%. HS: 34.3% consulted a doctor. Calls are greater with 30-39y women.	Strengths: Privacy. Response rate: 64.9% Limitations: Correlates of HS not explored. Helpline data indicative of callers' concerns only. Recommendations: Drs' awareness about sexual health

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Quinn et al., 2012 Queensland, Australia	To identify mental health nurses' views about psychiatric medication and sexual side effects	Exploratory qualitative research	Convenience sample of 14 nurses of 24-60 y [M = 44.4 y], working in one mental health service	Individual in-depth interviews; framework approach (Ritchie and Spencer, 1994); rigour	Only 4 nurses raise sexual issues with the patients. Themes: Assessment; Sexual side effects; Consumer embarrassment; pros and cons of information	Strengths: subjective views of nurses. Limitations: lack of transferability Recommendations: Address misconceptions about mentally ill patients sexuality; more studies
Rashid et al., 2011 Bangladesh	To identify the informal medical markets and providers in Bangladesh Not clearly mentioned	Quantitative descriptive and qualitative?	Random sampling of 303 providers and 312 married women of 14- 59y from two rural and one urban area of Bangladesh	Questionnaire on SDD, reproductive and sexual health [RSH], HS and providers. Piloted. Training of interviewers. In-depth interview SRH and HS with 63 women and 44 providers	RSH problems common but not discussed openly Barriers: shame/stigma. HS: provided largely via the informal market. 25% of providers had recognised degrees and medical training. Women prefer Drs and pharmacists. Treatment: vitamins, herbal tonics...	Limitations: Aim and design not mentioned; descriptive data; no discussion of the results

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Reed et al., 2012 USA	To determine the prevalence and characteristics of vulvodynia among women in southeast Michigan	Quantitative longitudinal	Population-based random sample of 2542 women, representative of women in a 4-county area in south eastern Michigan, using random digit dialling. 21.4% (544) ≥ 65 y	Questionnaire on SDD, reproductive health and vulvar pain and its characteristics; self-administered survey	Prevalence of vulvodynia 9.2%; higher among married and having intercourse and lower in black women. HS: 48.6% had sought treatment. 2.0% of all women screening positive for vulvodynia had been given the diagnosis of vulvodynia or vestibulitis	Strengths: critical evidence of the prevalence of this SP. Limitations: lack of generalisability; diagnosis may not be vulvodynia. Recommendations: Further studies to understand vulvodynia, among age groups
Rosen et al., 2012a USA	To determine the prevalence of Hypoactive Sexual Desire Disorder [HSDD] in women aged ≥ 18 in primary care or obs/gyn clinics	Cross-sectional survey	A stratified, cluster sampling of 701 women ≥ 18y [M= 46.2y] who use U.S. healthcare system in 20 clinics	Questionnaire on SDD and sexual function and dysfunction, sexual distress, physical-mental health, QOL, HSDD	SP: 7.4% with HSDD, more common among married, white and premenopausal women. HS: 28/52 [Readings, partners, friends]. 40% professional HS; 28/52 formal treatment [Hormone, sildenafil, herbs, antidepressant]	Strengths: sample broadly representative; accurate and replicable method for diagnosing HSDD

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Rosen et al., 2012b USA	To examine the socio-demographic, relationship, help seeking, sexual function, and medical characteristics of women with a clinical diagnosis of HSDD by menopause status	Cross-sectional survey	N = 1,574 women in 33 US clinical sites; women ≥ 18 y with HSDD; convenient sample; 42.9 ± 11.9 y	Self-administered questionnaire: sexual function, health, HS, relation satisfaction, QOL, HSDD severity and SDD. HS: reported or current treatment of HSDD	SP: 26.5% severe HSDD; more common in postmenopause; HS: partner, friend, Internet, readings; 7.6% no previous help; < half had HPs help, mainly from [obs/gyn]; 27.3% non-prescription. Barriers: perception of the problem-treatment; long-term relation Facilitators: desire to feel normal	Strengths: validated questionnaires, large and diverse sample. Limitations: Clinically based and convenience sample; probably women are more likely to seek help [selection bias]; Difficult to determine if the sample represents women with HSDD
Safarinejad, 2006 Iran	To explore the prevalence and risk factors of female sexual dysfunction (FSD) in Iran	Cross-sectional cohort study	Population-based two-stage cluster random sampling of 2626 women of 20–60 y. M= 31.2 y.	Self-administered questionnaire on FSD, medical history, toxic habits and medication	SP: 31.5% HS: 22% consulted the gyn. and 17% HPs; 63% would like to seek help. Facilitators: husbands' pressure; eagerness to have satisfying sexual intercourse and distress about normality	Strengths: High response rate; representative sample, validated tools Limitations: correlates of HS not discussed. Recommendations: new diagnostic category of sexual satisfaction disorder; epidemiologic research on FSD in

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	certain ethnic groups
						Strengths Limitations Recommendations
Sarkadi and Rosenqvist 2001 Sweden	To investigate women's wish to receive medical attention for their sexual disturbances	Qualitative study	Purposeful sample of 33 women, 44-80y, M= 65y±8.65y from education programme	Focus group; observation; Content analysis, co-researchers control for bias and triangulations	Factors that affect HS: Characteristics of the physician; generalist vs. specialist; and conditions in the healthcare setting	Strengths: women's views concerning factors that affect HS. Limitations: purposeful sample not explained
Saunamaki et al., 2010 Sweden	To describe Registered Nurses' [RN] attitudes and beliefs towards discussing sexuality with patients	Correlative and comparative design	A convenience sample of 88 RNs in five medical and five surgical wards in a Swedish hospital. 22-64 y. [M= 39.9y, SD= 11.0]	Questionnaire on SDD and Sexual Attitudes and Beliefs Survey SABS	Total SABS mean score 40.7 (SD=7.8)=barriers in discussing sexuality; > 90% knew the effect of diseases on sexuality; 2/3 relaxed in discussing the topic; but, most did not take time to do so; about 2/3 no ability to address the topic	Limitations: rigour about SABS translation not explained; small convenience sample size; no information on non- respondents. Recommendations: Teaching and guidelines in clinical units about sexuality care

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Shifren et al., 2009 USA	To describe the healthcare and information-seeking behaviour of women with self-reported sexual problems and distress	Quantitative cross-sectional	Population-based U.S. household survey of 3,239 women of ≥ 18 y with self-reported sexual problems/SP	Questionnaire on sexual function, sexual distress, SDD, HS.	SP: 44.2% and 12% with distress. HS: 34.5% formal; 41.9% informal mainly from the partner; 9.1% referred to anonymous sources; HS associated with SDD, health status /care system; 78.2% initiated 1 st discussion rather than HP; Source: mainly gyn and primary care physicians; 66% never had treatment	Strengths: large sample size; wide age range Limitations: cross-sectional design prevents temporal assessment of HS covariates outcomes. Data not collected on Drs' profile which may affect HSB. Recommendations: Drs' role in pushing women to discuss sexual health; provide adequate care
Vahdaninia et al., 2009 Iran	To investigate help-seeking behaviours among women with FSD in Iran	Quantitative cross-sectional	Population-based in primary health care centres. Stratified multi stage random area sampling of 1540 sexually active women ≥ 15 y. $M=33.2 \pm 9.4$ y	Questionnaire on FSD, HS, SDD. Piloted	SP: 51% HS: 35.8% no HS; 61% medical diagnosis and 57% treated. Source: gyn. mainly, Barriers: lack of time; perception of SD and HS; HPs' attitude. Facilitators: HPs' positive role; HS not related to SDD	Strengths: representative sample, Response rate 92%. Limitations: different aspects of FSD assessed by one question. Recommendations: address the problem both at local and national primary health care level

Author/s Year of publication Location	Aims of the study	Design	Sampling Population	Data collection	Key findings	Strengths Limitations Recommendations
Wendt, et al., 2009 Sweden	To describe young women's perceptions of being asked questions by midwives or doctors pertaining to sexuality and sexual abuse during visits for gynaecological examination.	Qualitative	Sample from a survey on women's sexual health chosen from eight midwife and youth centres for cervical screening in a county in the south-west of Sweden. 23-29y	Content analysis of two open-ended questions on women's attitudes towards discussing various aspects of sexuality and sexual abuse.	HS: Midwife and Dr can be trusted; Opening up a dialogue; Clarifying the situation; Context seems relevant; Drs/ Midwives empower; Sexuality is essential; Encroaching on the personal sphere Facilitators: Perception about sexuality and HPs Barriers: Privacy of sexual discussion	Strengths: rigour; transferability to similar groups of women and situations. Limitations: potential sampling bias Recommendations: Training midwives and doctors; further studies with other groups of women
Yildiz and Dereli, 2012 Turkey	To determine the views and attitudes of nurses on sexual counselling	Quantitative study [but mentioned qualitative]	103 nurses who work at a university hospital, 28.12 ± 4.72y	Questionnaire on the level of competence	17.5% perform sexual counselling; 27.8% trained in the field of SP and counselling; 22.2% lack information to provide counselling	Limitations: design and other methodological elements not explained. Recommendations: Education on sexual counselling

Appendix two

Information letter addressed to the administrators concerning women's participation in the study

This is an information letter that I address to you to get your permission to recruit women from your Organisation/Department to participate in a qualitative research study I am conducting in part fulfillment of the PhD requirements at the University of Dundee, Scotland – UK.

- Phase I: The purpose is to explore the meaning middle-aged women attribute to sexuality and their experiences in disclosing sexual concerns/problems and seeking help.
- Phase II: The purpose is to explore middle-aged women's understandings of sexual problems and the way they manage them.

The Ethics Committee/Institutional Review Board at the University of Balamand and Saint George Hospital University Medical Centre reviewed the study proposal and approved it as it respects ethical principles and has significance in the field of women's sexuality. The Institution Review Board approval is attached.

Women speaking Arabic and aged 40-55 years are eligible to participate in individual or focus group interview that will be conducted by the researcher (myself), a midwife - lecturer in the Nursing Programme, Faculty of Health Sciences - University of Balamand. Women who have acute or chronic health disease are excluded from the study. Eligible women will be recruited from the Organisation/Department. To preserve their confidentiality, the researcher would like to rely on the assistance of the staff to have the first contact with women to inform them about the study. Only those who accept to be interviewed will be referred to the researcher.

The researcher will meet with the selected women to clarify the study objectives and what is needed from them. She will inform them about their volunteer participation and the confidentiality of data. She will give them the opportunity to ask questions. Then, those who agree to participate will sign an informed consent and the interview will be conducted with them in a comfortable place of their choosing. The interviews will last about one hour and a half. Collected data will be securely stored by the researcher and the participants' names will be replaced by pseudonyms.

Findings will be disseminated through publications, seminars and conferences. This will further the understanding with respect to the understanding of sexual problems and the pathways to help-seeking and give educators, researchers and professionals the

opportunity to improve women's sexuality and empower them to meet their sexual needs.

I stand ready to respond to queries and provide additional information. I can be reached at Mathilde.azar@balamand.edu.lb or by phone. You can also refer to my primary research supervisor Dr Thilo Kroll who is accessible on the following email: t.kroll@dundee.ac.uk

I look forward to receiving your favourable response.

Sincerely

Mathil Azar

Appendix three

Information letter addressed to the administrators concerning nurses and midwives' participation in the study

This is an information letter I address you to get your permission to recruit nurses and midwives from your Institution/Department to participate in a multiphase research study I am conducting in part fulfillment of the PhD requirements at the University of Dundee, Scotland – UK. The purpose of the study is to understand the meaning of sexuality for middle-aged Lebanese women and explore their views and experiences with sexual difficulties and the facilitators and barriers to help-seeking. Nurses and midwives will reflect on their role in sexuality-related care.

The Ethics Committee/Institutional Review Board at the University of Balamand and Saint George Hospital University Medical Centre revised the study proposal and approved it as it respects ethical principles and it has significance in the field of women's sexuality. The Institution Review Board approval is attached.

All professional nurses and midwives who are engaged in direct patient care are eligible to participate in focus group interviews that will be conducted by the researcher (myself), a midwife - lecturer in the Nursing Programme, Faculty of Health Sciences - University of Balamand. Eligible nurses and midwives will be recruited from the Institution/Department.

The researcher will choose the participants with the assistance of a responsible nurse in the Nursing Administration. She will meet with them to clarify the study objectives, what is needed from their participation. She will inform them about their volunteer participation and the confidentiality of data. She will give them the opportunity to ask questions. Then, those who agree to participate will sign an informed consent and the interview will be conducted with them in a comfortable place of their choosing. The interviews will last about two hours. Collected data will be securely stored by the researcher and the participants' names will be replaced by pseudonyms.

Findings will be disseminated through publications, seminars and conferences. I expect that the study will further our understanding of women's sexuality and help-seeking for sexual problems and give educators, researchers and professionals the opportunity to improve women's sexuality. Findings will also allow us to empower women to meet their sexual needs.

I stand ready to respond to queries and provide additional information. I can be reached at Mathilde.azar@balamand.edu.lb or by phone. You can also refer to my primary

research supervisor Dr Thilo Kroll who is accessible on the following email:
t.kroll@dundee.ac.uk

I look forward to receiving your favourable response.

Sincerely

Mathil Azar

Appendix four

Topic guide of the individual interviews with women - phase I

Participant's name and pseudonym
 DatePlace of the interview
 Recruitment place
 Comments.....

Preamble

Before the beginning of the individual interviews, women were welcomed and thanked for their participation in the study. Their consent to participate in the study and get the interview audio-recorded was reasserted. Women were assured that all that they say is important and not judged as good or bad; the most important is their views concerning the discussed items. Then, they were introduced to the context of the study.

Introduction

The topic guide contains a series of open-ended questions that aim at exploring the meaning of sexuality for the middle-aged Lebanese women and understanding what factors determine their decision to seek help when sexual concerns arise. It also includes questions about the sociodemographic profile, menopausal and health status. The topic guide is articulated around a vignette that illustrates the case of a woman concerning sexual disclosure and help-seeking. You are kindly asked to reflect on this case and give your opinion and experience in the field.

Vignette

As a health professional working in a program of women's health, I was carrying out an interview with a 49 year-old woman to get information about her health status. When I asked the woman about her sexual life and possible concerns or complaints, she answered that 'I prefer not to talk about this part of my life'.

1. How would you describe the woman's viewpoint in the discussion of issues related to her sexual life? Do you think all women would have the same viewpoint?

Probe What do you think about sexual disclosure? What are the issues you may divulge or talk about and what are other issues you may keep hidden and why?

2. What does sexual life mean to you? What might affect sexual life?

Probe How would you describe sexual life? What are the terms you use to describe it? What you would say about your sexual life and why?

After a while she began talking and told me that around menopause, her sexual life had changed and since then she has had some sexual concerns. She said that she was not sure what she should do.

3. Can you tell me what it has been like having sexual changes for a woman around the menopausal period?

Probe What are the changes you have encountered in this period of your life? Can you talk about your experience?

4. What could be done to help women deal with their sexual concerns or problems?

Probe What advice could be given to this woman about the type of help to seek, where to seek help, who to talk to and why?

5. What would you personally do or consider doing to deal with sexual concerns or problems ?

Probe What is your experience?

6. Can you tell me about the facilitators and obstacles for women to seek help and discuss their sexual life concerns?

*Probe What might push you to seek help for sexual concerns or problems?
What might refrain you from seeking help for sexual concerns or problems and why?*

7. What advice would you have for professionals to better support women who suffer from sexual concerns or problems?

Probe What are the characteristics of the helper? How would you describe him/her? What do you expect from him/her?

8. Is there anything else you would like to share with me, or to advise this woman about her sexual life and concerns?

9. How did you find the discussion about the topic?

Probe What are the benefits and risks of sharing your sexual concerns with someone else?

Socio-demographic data, general health and menopausal status

1. How old are you? -----
2. What is your current marital status? -----
3. If married, from how long? -----
4. What is the highest education level attained? -----
5. How would you classify your economic status?
☐Good ☐Medium ☐Low
6. What is your current employment? -----
7. What is your religious affiliation? -----
8. How would you describe your general health?
☐Good ☐Acceptable ☐Poor
9. How do you currently describe your menstrual cycle?
 - a. ☐Regular menses
 - b. ☐Irregular menses have occurred in the past 3 months (3 - 12 months)
 - c. ☐Menses ceased at least 12 months ago

Closure

- Summarising findings to the women and asking her if they have something to add or withdraw.
- Thanking women for their participation.
- Providing those who wished to keep in touch with me with my phone number
- Referring those who expressed the need for help to a specialist.

Appendix five

Topic guide of the confirmatory focus group interview with women - phase I

Participant's name and pseudonym
 DatePlace of the Interview
 Recruitment place
 Comments.....

Preamble

Before the beginning of the focus group interview, women were welcomed and thanked for their participation in the study and introduced to one another. Their consent to participate in the study and get the interview audio-recorded was reasserted. Women were assured that all that they say is important and not judged as good or bad; the most important is their views concerning the discussed items. Then, they were introduced to the context of the study.

Introduction

The purpose of the focus group interview is to discuss the key findings generated from individual interviews conducted with 18 women about the meaning of sexual and the factors that shape help-seeking for sexual concerns/problems. The topic guide also includes questions about the sociodemographic profile, menopausal and health status. Kindly give your opinion concerning the following statements.

Questions

1. In the discussion I had with the participants, they reported that sexual life is very important; it is a source of pleasure and satisfaction. Yet, they perceived sexual life as a sacrifice to satisfy their husbands to protect the family boundaries regardless of their own sexual needs. Otherwise, they expressed fear of their husbands engaging in affairs.

What do you think about the participants' perception of sexual life?

Probe Are their views congruent with yours? What else would you like to say in this regard?

2. The majority of the participants told me that a men's sexual life is free, rather physically oriented and continues throughout their lifespan. However, the female sexual life is short and emotionally bound; if women voice their sexual needs, they are judged with prejudices. They added that around menopause they are afraid to

lose their femininity and attractiveness; consequently their husband might be attracted to other women.

- a. What do you think about women's description of their sexual life in comparison to that of men's?

Probe How you might differentiate between men's and women's sexual life? Explain.

- b. How does women's perception of their sexuality with menopause relate to your views? To what extent do you think women lose their sexual life around menopause?

Probe How menopause might affect sexuality? What are the changes that may happen?

3. For the majority of the participants, sexuality is a taboo and private issue. It is a silenced discourse between parents-children and in the society. They do not like to discuss or report on it especially when their husbands are accused of sexual problems.

- a. What about the participants' silence around their husbands' sexual problems? Why this might happen?

Probe What is your opinion concerning sexual disclosure and how this might be influenced?

How about participants' silence on their husband's sexual dysfunction to protect his virility?

4. The participants claimed that they do not have female sexual problems as these are mostly male related.

- a. Would you like to comment on women's perception of sexual problems?

Probe Tell me what the term sexual problems means to you? What do you think has shaped your ideas about sexual problems?

5. In case they had sexual problems, the participants would mainly rely on the support of their husbands and sometimes on their friends and relatives. However, they said that they are ready to seek professional assistance if sexual problems become a threat to their marital life.

- a. What is your opinion about this?

Probe What would you do if you were faced with sexual problems and why? What might affect your decision to seek professional assistance?

6. The female gynaecologist followed by the psychiatrist/psychologist, are the first source of professional help for the participants. They expected these professionals to be knowledgeable, trustful, good listeners, helping them to talk in a warm and trustful environment.

- a. How you might explain the participants' choices and expectations concerning the professionals?

Probe Who you might refer to for sexual problems and why? What are the characteristics of your preferable helper?

7. The majority of the participants did not accept that the professionals initiate a discussion with them about their sexual life issues if they do not themselves identify the need for it.

- a. Why do you think the participants do not agree to be asked by the professionals about their sexuality?

Probe What is your personal opinion about the professionals' initiation of a discussion with you about you about the subject?

- b. In your opinion, why the participants did not consider other professionals like particularly nurses and midwives as a source of help for them?

Probe How do you look at nurses and midwives role in sexuality-related care?

Socio-demographic data, general health and menopausal status

1. How old are you?
2. What is your current marital status?
3. If married, from how long?
4. What is the highest education level you have got?
5. In which category do you classify your economic status?
6. ☐ Good ☐ Medium ☐ Low
7. What is your current employment status?
8. What is your religious affiliation?
9. How would you describe your general health?
☐ Good ☐ Acceptable ☐ Poor
10. How do you currently describe your menstrual cycle?
 - a. ☐ Regular menses
 - b. ☐ Irregular menses have occurred in the past 3 months (3 - 12 months)
 - c. ☐ Menses ceased at least 12 months ago

Closure

- Summarising data to the women and asking them if they have something to add or withdraw.
- Thanking women for their participation.
- Providing those who wished to keep in touch with me with my phone number.
- Referring those who highlighted the need for help to a specialist.

Appendix six

Topic guide of the individual and focus group interviews with women - phase II-A

Participant's name and pseudonym
 DatePlace of the Interview
 Recruitment place
 Comments.....

Preamble

Before the beginning of the individual or focus group interviews, women were welcomed and thanked for their participation in the study. Their consent to participate in the study and get the interviews audio-recorded was reasserted. Women were assured that all that they say is important and not judged as good or bad; the most important is their views concerning the discussed items. Then, they were introduced to the context of the study. [In the focus group discussion, women were introduced to one another].

Introduction

The purpose of this interview is to explore how the middle-aged women understand sexual problems and how their views are shaped. It also explores the way they manage their sexual problems. The topic guide comprises a series of open-ended questions about the subject in addition to other questions about the sociodemographic profile, menopausal and health status. You are kindly requested to reflect on your views and experiences concerning the following questions.

Questions

1. How do you describe a good sexual life?

Probe What are the characteristics of a good sexual life? What does it come to your mind when I say good sexual life? What are the things that you expect to have within sexual life?

2. What would you consider to be a sexual problem? Can you explain this? Why do you think this is the case?

Probe What words or phrases come to mind that are synonymous with sexual problems for you? What might be the factors that relate to women's sexual problems?

3. How do sexual problems affect women's lives?

Probe How personal, marital, family life and other issues might be affected by sexual problems?

4. Please describe any sexual problem that you have encountered in your life. How has this affected you?

Probe What would you consider to be problematic for you in sexual life?

5. How would you deal with a sexual problem? What is your experience at this level?

Probe What are your sources of help? Where do you go? To whom do you talk to? Have you ever sought help for any sexual problem?

6. What are the facilitators and barriers to seeking professional assistance?

Probe What might encourage you to seek help for a sexual problem? What might prevent you from seeking help?

7. How do you get information about sexuality and sexual problems? What are the factors that might interfere with the acquisition of sexual information?

Probe Do you think that you have enough knowledge about the topic? Would you like to know more about the topic? What would you like to know?

8. How do you describe the role of nurses and midwives in women's sexual health/sexuality-related care?

Probe What are your expectations of them? What would you like them to do for women's sexuality?

9. Any other comments or something you would like to say?

10. How have you found the discussion?

Socio-demographic data, general health and menopausal status

1. How old are you? -----
2. What is your current marital status? -----
3. If married, from how long? -----
4. What is the highest education level you have got? -----
5. In which category do you classify your economic status?
☐ Good ☐ Medium ☐ Low
6. What is your current employment status? -----
7. What is your religious affiliation? -----
8. How would you describe your general health?
☐ Good ☐ Acceptable ☐ Poor
9. How do you currently describe your menstrual cycle?
 - a. ☐ Regular menses
 - b. ☐ Irregular menses have occurred in the past 3 months (3 - 12 months)
 - c. ☐ Menses ceased at least 12 months ago

Closure

- Summarising data to the women and asking them if they have something to add or withdraw.
- Thanking women for their participation.
- Providing those who wished to keep in touch with me with my phone number
- Referring those who highlighted the need for help to a specialist.

Appendix seven

Topic guide of the focus group interview with nurses and midwives: Phase II-B

Participant's name and pseudonym
 DatePlace of the Interview
 Recruitment place
 Comments.....

Preamble

Before the beginning of the focus group interview, nurses and midwives were welcomed and thanked for their participation in the study and introduced to one another. Their consent to participate in the study and get the interview audio-recorded was reasserted. Nurses and midwives were assured that all that they say is important and not judged as good or bad; the most important is their views concerning the discussed items. Then, they were introduced to the context of the study.

Introduction

The purpose of this focus group interview is to understand nurses and midwives' perception, attitude and practice concerning patients/women's sexuality-related care. The topic guide contains a series of open-ended questions about the subject in addition to sociodemographic questions. You are kindly requested to reflect on your views and experiences concerning the following questions.

Questions

1. Why have you come today?
2. What do you understand by having a healthy/good sexual life?
3. What is your role in women's sexuality/sexual concerns and problems?
Probe What is the meaning of sexuality-related care within your practice?
4. Could you describe any 'practice as a nurse or midwife' where you had to deal with women who expressed sexual concerns and problems?
Probe How would you find yourself in the delivery of sexuality-related care within your practice?

5. The majority of the women I interviewed did not have a clear idea about the role of nurses and midwives in sexuality-related care. Can you think of reasons why this might be?

Probe What are the factors that may interfere with your practice in the field (personal, organisational, cultural, patients, etc.)

6. Some women told me that nurses and midwives can be change agents in women's sexuality, sexual concerns and problems. What do you think about this? How you might be change agents?

Probe What would you suggest could be changed to help you provide better support for women with sexual concerns and problems?

7. Can you think anything else that health professionals can do to support women?

8. Is there anything important that you want to discuss?

Sociodemographic characteristics

1. How old are you?
2. What is your current marital status?
3. If married, from how long?
4. What is your major?
5. What is your education level?
6. What is your current area of work?
7. What is your professional status?
8. What is your religious affiliation?

Closure

- Briefing on findings to the nurses and midwives and asking them if they have something to add or withdraw any information.
- Thanking nurses and midwives for their participation.

Appendix eight

Thematic framework of the data generated with women: Phase I

	Categories/codes	Description
1	Perception of sexual life	How women perceive their sexual life
1.1.	Sexual life: 'a necessity for man and woman'	The importance of sexual life for the individual wellbeing
1.2.	Sexual life: 'a marital unifier and family stabiliser'	The importance of sexual life in gaining agency to protect the family
1.3.	Gender-based sexuality	The perceived difference between men's and women's sexuality
2.	Contextual and relational influences on sexual life	It describes how sexual life is affected by the relation with the husband and daily life events
2.1.	The husbands' attitude and behaviour	The husband is described as the main player in sexual life
2.2.	Life burdens and stressors	Women reported on stressful situations that interfere with sexual life
2.3.	Children at home	The presence of the children is intimidating particularly when they grow older
3.	Societal norms about sexuality	How social values and norms shape sexuality
3.1.	Lack of awareness	Women criticised their conservative upbringing that resulted into their awkwardness
3.2.	Inhibition	Women reflected on their incapacity to express their sexuality
3.3.	Sacrifice	Women claimed having sex for their husbands' satisfaction
3.4.	Intergenerational changes	Role of media in inducing openness and changes between the generations
4.	Sexual disclosure	Women reflected on their silent sexual discourse
4.1.	Taboo	It discusses the stigma/shame around the general discourse of sexuality
4.2.	Secrecy	The spouses' privacy is interpreted as a commitment to one another
4.3.	A must between spouses	It stresses on the need for the spouses to discuss their sexual likes and dislikes
4.4.	Gender-based intergenerational	It describes how parents-children communication about sexuality is regulated by the gender

	communication about sexuality	[mother-daughter and father-son]
5.	Menopausal changes	<i>It describes how sexuality is perceived with menopause</i>
5.1.	Perceived positive menopausal changes	Women reflected on the physical relief and free sex life with menopause
5.2.	Perceived negative menopausal changes/sexual problems	Women expressed their fear of losing their attractiveness and femininity with menopause
5.3.	Advices about negative menopausal changes	It talks about medical strategies to reduce the effect of menopause on sex life
6.	Help seeking for sexual problems	<i>Women refer to a source of help for their sexual problems</i>
6.1.	The talk about sexual problems	It describes the challenges to disclose sexual problems
6.2.	Sources of help	Women talked about the unavailability and inaccessibility of help and their unawareness about the sources of help
6.3.	The husband is the first source of help	women stressed on the support of the husband to manage sexual issues
6.4.	The gynaecologist mainly and the psychiatrist as reliable sources of help	They identified the reasons to rely on these professionals and described the preferred characteristics and expectations of them.

Appendix nine

Thematic framework of the data generated with women: Phase II-A

	Categories/codes	Description
1.	<i>Good sexual life or Sexual wellbeing</i>	<i>Women discussed the requirements of a successful sexual life governed by love, exchange and respect</i>
1.1.	Sexual awareness and education	It talks about the importance of sexual information that is lacking among women
1.2.	Communication in sexual life	Women stressed on spouses' exchange as a way to understand one another needs and concerns
1.3.	Acceptance /respect of the other	It discusses the consideration of everyone's sexual self
1.4.	Caring for the multidimensional aspect of sexual life	It talks about the personal, relational and environmental factors that interfere with sexual life and wellbeing
1.5.	Reciprocity of sexual life and general wellbeing	Women discussed how these two elements are mutually linked
2.	<i>Sexual life</i>	<i>Women described their perception of sexual life at the personal and relational level</i>
2.1.	Women's devotion in sexual life; the other's needs	It is about women's sacrifice to satisfy their husbands
2.2.	Gender discrepancy in sexual needs and desires	It reflects the physical and emotional differences between men's and women's sexuality
2.3.	Changes in sexual life	The changes that happen with menopause and ageing
2.4.	The personal context of sexual life	It describes women's sexual interest and disinterest as part of their general context and marital relationship
2.5.	Importance of sexual life	It describes how sexual life is important for the personal and family wellbeing
2.6.	Sexuality and social morality	It talks about the taboo aspect of sexuality and the respect of social norms which result into women's inhibition
2.7.	Woman's power in sexual life	It reflects on women use of sex to gain power with their husbands
3.	<i>Sexual problems</i>	<i>Sexual problems are defined as biopsychosocial</i>
3.1.	Unawareness	Women discussed how their sexual unawareness and inhibition affected their sexual self

3.2.	Physical and psychosocial	Women identified ageing, negative mood, fatigue, financial burdens, life stressors and the presence of children as inhibitors of their sexual life
3.3.	Husbands' sexual problems	Women attributed sexual problems to their husbands' [early ejaculation and impotence]
3.4.	Relational problems	Women talked about the marital conflicts, husbands' inappropriate attitude and behaviours and their impact on sexual life
3.5.	Consequences of sexual problems	Women discussed the impact of sexual problems on her emotional, relational and family life
4.	Help-seeking	Women discussed the different sources of help and the facilitators and barriers to this behaviour
4.1.	Husband understanding and support	It situates the important place of the husband in dealing with sexual problems
4.2.	The gynaecologist	This physician is described as the most reliable source of help
4.3.	Quality of the resources	Women described the characteristics of the helper and criticised the available resources
5.	Facilitators of help-seeking	It is about the factors that push women to refer to a professional
5.1.	Satisfying the husband	Women's willingness to seek help is triggered by their willingness to satisfy their husbands
5.2.	Keeping the cohesiveness of the family	Sexual life is perceived as a unifier
5.3.	Women empowerment to talk	It identifies some suggestions that empower women to overcome their inhibition and seek help
6.	Barriers to help-seeking	Women identified many factors that prevent them from seeking help for sexual problems
6.1.	The husbands' resistance	It shows the husbands' power and selfishness, refusing to address their sexual problems
6.2.	Women's resistance	It talks about women's timidity, doubtfulness about the solutions of sexual problems and their sexual disinterest
6.3.	Problems with resources	It is about the lack of resources, unawareness about the sources of help and dissatisfaction with sexuality-related care
7.	Role of nurses and midwives	It talks about the controversial perception of these professionals role in sexuality-related care

Appendix ten

Thematic framework of the data generated with nurses and midwives: Phase II-B

	Categories/codes	Description
1.	<i>Role of nurses and midwives in sexuality-related care</i>	<i>The nurses and midwives reflected on their perception and experience of their role</i>
1.1.	Perception of sexuality and sexual problems	It reflects on the importance of sexual life, women's inhibition and the high prevalence of sexual problems
2.	<i>Discussion of sexuality-related issues</i>	<i>Nurses and midwives discussed their controversial opinions about their role in sexuality-related care</i>
2.1.	Breaking the ice	It describes the strategies to encourage sexual discussion
2.2.	Sexual discussion is difficult	Nurses and midwives identified many barriers to have an effective role in sexuality-related care
2.3.	Talking about sexuality; whom initiative	It talks about the characteristics of the professionals who are expected to deal with patients' sexual concerns
2.4.	Lack of preparedness	Nurses and midwives critiqued the nursing and midwifery education in the field of sexuality
2.5.	Patients' fear of stigmatisation	It is about the patients' avoidance of sexual disclosure as it is taboo
2.6.	Healthcare system influences	It describes the barriers to sexuality-related care at the level of the organisational structure and role distribution
3.	<i>Dealing with embarrassment</i>	<i>It discusses the strategies used to overcome the embarrassment related to sexual discussion</i>
4.	<i>Promoting sexuality-related care</i>	<i>It presents the suggestions to promote nurses' and midwives' role in sexuality-related care</i>

Appendix eleven

Example of overlapping quotes

	Importance of sexual life	and	Sexual awareness and education
Elsie	<i>... Sexual relation and sexual issues are very important in life. We have to protect them. There should be awareness. Sexual life is very interesting. The health professionals do not care. The TV programmes about sexuality are daunting. Women are not able to say what they want. Education is important. If the person is capable, why he does not enjoy her sexuality? Why'?</i>		
	Gender discrepancy in sexual needs and desires	and	Women's sacrifice/inhibition
Beatrice	<i>In our life, it is usually man who arouses woman and not the opposite... It is very difficult for a woman in case she tries to arouse her husband and he does not accept. It is just for his pleasure; not more than that because man has more pleasure, more than woman ... Man does not care. He will tell her, you do not want I can look at another woman.</i>		
Chaten	<i>We obey our husband. He has the urge to do sex. We run and act as if we were so interested just to help him and avoid his embarrassment. We had many similar circumstances and we did not let him feel dissatisfied.</i>		

Appendix twelve

Example of the thematic chart

	I. Sexual Problems		
	3.1. Psychosocial and environmental	3.2. Husband's sexual problems	3.3. Relational problems
Tamara	<i>The problems are mental, environmental and social; even financial problems affect without doubt this (sexual life). When I talk about the acceptance of the other, you need suitable circumstances to accept the other, or to stay with him...</i>	<i>But, he can do nothing... he tries and he hardly gets there [ejaculate]... I try to tolerate him... but, sometimes I cannot...</i>	
Zeina	<i>... You do not have a normal sexual life because you are trapped by social problems... sexual life and sexual health are affected by social issues...</i>		
Sally	<i>By the way, sorry, I do not have any sexual desire, unless he insists on me. No way [stressed on her words], I never have the desire...</i>		
Beatrice			<i>Sexuality is the result of physical and emotional interaction between the two partners. If they are not in good terms, it is so difficult to have sex. Woman will not be responsive and will not enjoy it.</i>
Lana		<i>Sometimes I tell myself, why this man only once per month (makes sex), is</i>	

		<p>it possible that he is cheating on me? ... I try to think about something else... I flee the subject (p3)...It is not a shame; it is my right to enjoy. But I feel that my husband cannot; he cannot do this effort...I have to understand him... I convince myself that I am frigid.</p>	
	7. Menopausal changes		
	7.1. Perceived positive menopausal changes	7.2. Perceived negative menopausal changes/sexual problems	7.3. Advices for negative menopausal changes/sexual problems
Inass	<p>I feel that on the contrary; more you get older more you like sexual life. Maybe menopause causes depression because this is a transitional period of woman's life. Menstrual cycle makes you feel that you are still young and very active; you have energy and vivacity. You refuse not to get your menstruation. If you realise that you will not get it anymore or you are close to menopause, you will get depressed. But on the contrary, I know menopausal women whose sexual life persisted. This is more comfortable; she can sleep with him at anytime (no fear of pregnancy).</p>		

Hana		<i>When we were young, in the thirties, we were every other day (making sex). But now no; every week, 10 days, 15 days and it does not matter. Now my husband has hypertension.</i>	
Dima			<i>When the menopause happens, man still has the need (for sex) while this does not mean anymore for his wife. Then you are afraid that man will look out and does relations out. This is a problem. That is why it would be better if the science encourages the delay of menopause. This is good for her physically, physiologically, and for the relationship... As long as the woman is still strong and able to fulfill her duties and do sex, her life is more successful.</i>

Appendix thirteen

Example of data translation at the level of the thematic chart

Name	Code	
	2.	Sexual problems are male-related
	2.1.	Selfish
	2.2.	No control on himself
	2.3	Insistence to have sex
	2.4.	Sex is instinctive for him
	2.5.	Not attentive to his wife's needs
	2.6.	Using undesirable ways
	2.7.	Cannot get easily aroused/trying different ways
	2.8.	Relational problems
	2.9.	Impotence
	2.10.	Perversion
	2.11.	Early or late ejaculation
Mada		<p>p2. 2.1.1./2.1.10.</p> <p>ليش برأيك وصلت لهدا الوضع؟ هو كان عنده مشكلة بالأول إنو كل ما بيقرب ما بيخلص، هو لحاله يعني بيخلص وأنا ولا شيء ولا شيء ولا شيء وصارت ولا شيء. يعني أنا وين، أنا أقول له لشو ضيعاتو، واحد ما بيوصل لمطرح بنصف الطريق... هو هيك، اتحكم، ما بيتحكم، وضلينا هيك يعني... يعني أنا ما بتهمه راحتي، عرفت كيف، بالأول وقت يلي ما كان في ولاد، كان يجرب إنو يوصلني بس هلا لا ما بتفرق معه ولا أنا بقى طالب لأن كمان ما بقى تفرق معي</p>
Mada	P2. 2.1.1./2.1.12	<p>Why do you think you arrived to this situation? At the beginning my husband had late ejaculation. He enjoys alone and I feel nothing, nothing, nothing. I arrive at the middle of the road and then, there is nothing (she is aroused but does not reach her orgasm). He refused to treat himself and this is our situation... He does not care about me especially now since children grew older. I do not anymore ask him to care about my satisfaction; I do not care any longer.</p>
Odile		<p>p2. 2.1.1./2.1.12.</p> <p>شو يالي عمبيخلليك تشكي من حياتك الجنسية؟ عدم اشباع رغبتني. يعني اول شي الرجال لما يكون في فرق عمر بصير يجي ظهرو بسرعة، بتكون هي ما وصلت للذة وهو بس يجي ظهرو بingham-طبيب وأنا؟ من هون بحسن بتبش المشاكل الزوجية انو انا وين حقي عندك؟ أولتي نحن في فرق مليح بالعمر</p> <p>p2-3.</p> <p>يعني مثلاً "إذا بتقولي مع العمر بيخف عنده، بيقتصر العضو..."</p>

	<p>بيقصر العضو يعني من بعد ما يفضي بيطل في عندو صلابة. بتطل المرأة تحس ائو في شي فيا، عرفت كيف.</p>
Odile	<p>p. 2. 2.1.1./2.1.12. Why you are complaining of your sexual life? I do not have my sexual pleasure satisfied. If there is a difference in age, man will get his orgasm rapidly while she has not yet reached her orgasm. He will sleep and leave me without thinking about my sexual rights. Thus problems start. Ok there is a big difference in age between him and I?! p. 2-3. With age, the penis becomes shorter because there is no good erection. She will not anymore feel that there is something inside her.</p>

Appendix fourteen

Example of the analysis process of the data generated with women

Illustrative Quotes	Codes	Sub-themes	Theme
<p>In her upbringing, woman inherited the interdiction and taboo. She inherited the story of her mother and grand-mother who attribute to man a distorted portrayal that exists in their mind and does not necessarily correspond to the reality. Accordingly, woman will construct a bad image about man and will have an offensive attitude toward him.</p> <p>Our parents possess our body, our life. But, I was able to take it (my life) from them in a peaceful way, understand it and live it. I understood what sex is; I am now enjoying it. They deprived us from the most pleasurable thing we can live (Carmen).</p>	<p>Inhibition/ taboo/ Negative beliefs</p>	<p>Unawareness</p>	
<p>... If I talk about the topic (her husband sexual problems) with him I will feel bashful. I will feel it arrogance as if I wanted and was keen for it and he could not (Lana).</p>			
<p>How much we have beliefs about the relation that we took and heard and that we want to apply in the relation... And he has his own beliefs... Initially you are not aware about these issues until you get a big problem that shakes you... You then ask yourself so what am I doing? ... It would be possible to adjust these beliefs to improve the relation. If not we will continue with the taboo that drives our life... (Raja).</p>			
<p>One cause of sexual problems is the absence of sexual education in Lebanon. This is so wrong. She does not know how to discover her body and how to enjoy with her husband. In our society, the woman is not at all aware about sexual life when she gets married. Her husband will not enjoy too. (She got married at her 30s). She takes time to discover her</p>	<p>Lack of sexual education</p>		

body (Faten).			
Sexual life changes with age. The hormones change as well as the libido. The feelings change and the body change and these changes affect sexual life. Man might go out if he is attracted by a woman. The frequency reduces (Faten).	Ageing	Physical	Sexual problems
Infertility causes sexual problems. I had my unique son after 12 years of marriage. I arrive till the point where I hated sex when it was outside ovulation. But I do not let him feel that I do not want (Odile).	Infertility		
Man has more desire than woman. For me I do it sometimes just to please him. But man's desire is greater... Man is always ready, but woman no. She has to be physically and psychologically comfortable to do this. For man it does not matter... Man has it as an urgent need; more than woman (Dima).	Discrepancy in desire		
It is very important for woman to enjoy, not having pain or being uncomfortable. Otherwise, she will totally refuse sex... (Dalia).	Lack of sympathy/ comfort	Psychosocial	
Sexual problems might have a psychological rather than physical cause. If I cannot feel myself fully with him I cannot enjoy sex. Sexual problems cause psychological problems. In turn, woman will avoid having sex to avoid showing her sexual problems; this is a weakness for her... (Lea).			
I got family problems and became unable. He was enjoying sex; but I was not... (Pamela).	Family issues/ Presence of children		
Psychosocial pressure causes sexual problems; responsibilities, worries, financial problems. she is more affected than man by these issues... (Jana).			
... with the growth of the children, sexual relation became intimidating and less frequent... (Mada).			
Woman might be timid especially when there are children although sexual life is legitimate			

(Irene).			
The problems are mental, environmental and social; even financial problems affect without doubt this (sexual life). When I talk about the acceptance of the other, you need suitable circumstances to accept the other, or to stay with him... (Tamara).	Multifactorial		
Sexual problems?! When man is selfish. This is in his nature. He does not care about his wife if she enjoys or not. He does not control himself. His wife let him think that she enjoyed. Another issue relates to man insistence to have sex regularly ignoring her fatigue and concerns... Man is driven by his instincts. In the majority of sexual relationship, women do not enjoy. It is all about the psychological context of the sexual relation (Dalia).	Men selfish instinctive	Relational	
I had sexual problems because he insists for anal sex. I do not accept because I am not an animal to treat me in this way. If he loves me he has to take care of me to be able to give him with love... (Sara).	Anal sex		
The most important sexual problem for woman is one he wants sex while she does not want. This is my problem with him... This might be related to their upbringing, following mother's habits... (Dalia).	Forced sex		
He does, he struggles and I feel nothing... he becomes tired, he cannot; he turns his back and sleeps... He cannot although he tries; and imagine that! he does not accept (to consult). What can I do? I shut up... (Lana).	Sexual impotence/ Ejaculatory problems		
Sexual problems affect your psyche, your life with your husband, children; you become nervous (Jana).	Emotional/ relational/ familial		
Sexual problems make woman nervous because she is not on good terms with her husband. This will mainly affect children (Gaby).			
I passed by this experience; if I did not talk	Emotional/		

about this problem, our household would have been ruined. It leads to a complete sexual frigidity. You will lose your affection, your desire, for this issue. If he tells you he wants to sleep with you?!, you say no. you become disinterested... (Pamela).	<i>familial</i>	Consequences of sexual problems	
Sexual problems affect her physical and psychological growth. It is like when you tell her to stay without education. You get lost especially if you are not with someone who understands you (Carmen).	<i>Emotional/ Physical</i>		
Sexual problems severely affect woman's psyche... Sex does not succeed if it is not driven by woman's feelings and the husband is attentive to these feelings... I am so upset and disappointed, desperate. I do not like him any longer... (Dalia).	<i>Emotional</i>		

Appendix fifteen

Example of the analysis process of the data generated with nurses and midwives

Illustrative Quotes	Codes	Sub-themes	Theme
<i>The patient waits for someone to ask him. I asked him what happened with you? I did an assessment and took the history... and he talked about the erection and ejaculation problems... (Rea).</i>	Good assessment	Breaking the ice	Discussion of sexuality-related issues
<i>Every day during my morning round I interview every patient and ask him/her about his/her concerns otherwise, the patient does not talk... (Adrea).</i>			
<i>You have to listen to her. You have to try... sometimes she throws a word and waits for our reaction to see if she can open up and tells us her concerns... you have to be careful because one word could be a cue... (Adrea).</i>	Attentive listening and time dedication		
<i>When you enter the patient room and you give her time and attention... In order to take, you have to give... (Adrea).</i>			
<i>Sometimes we do not give importance to the patient discourse... we have to be careful... (Nahla).</i>			
<i>Bring a paper and write down all your questions... ask and do not be shy... ask all what it comes to your mind... (Adrea)</i>	Trigger women to talk		
<i>Because someone came, broke the ice with the patient and triggered the patient to talk... you initiated the conversation... you gave the patient the opportunity to talk... (Rea).</i>			
<i>You show her you are not here to judge you understand her you are ready to listen and you are ready to help... (Dzovinar).</i>	Matter of trust		
<i>It's a matter of trust to let the patient talk (Melissa).</i>			
<i>Initially this discourse could not be opened unless you trust the person in front of you and you are sure that this person will listen to you and keep your talk confidential (Jennifer).</i>			
<i>As part of the childbirth preparation classes, we as midwives become close to the couples; they trust us and we discuss with them sensitive issues (Melissa).</i>			
<i>I would like to tell a story just to confirm you that the severely ill patients are the most ones who talk about the subject. (sexuality...) (Adrea).</i>	Sexuality is the patient priority	Talking about sexuality;	
<i>She had a decreased libido and vaginal dryness because of her disease (multiple sclerosis). She was waiting for me to come to</i>			

<i>tell me about her problems (Nahla).</i>	<i>Sick patient does not care about sexuality</i>	whom initiative?	
<i>I do not care if the patient's sexual needs are fulfilled whereas there are other important issues (Damy).</i>			
<i>Frankly, in the oncology unit where the majority is going to death, this subject is not anymore very important (Sabrine).</i>			
<i>Write everything on a paper and then when he comes (the physician) ask him. I myself, I do not know... (Adrea).</i>	<i>Knowledge</i>	Lack of preparation	
<i>It is the lack of knowledge that causes the limitation to address the topic... (Rea).</i>			
<i>For me, my mom did not inform me about these things. During my first year of university study I was unable to differentiate the meatus from the vagina and clitoris... We were looking at each other in class astonished... we were ignorant... still our midwifery education was not enough... I do not know what to answer a woman when she tells me something about her sexual relation... what I have to tell her?!... (Noel).</i>			
<i>We learned that the topic is intimate. That is why we have not yet reached the point where we are able to approach it easily or consider it as a concern like other topics (Rayan).</i>	<i>Attitude</i>		
<i>From my view, all what related to medical surgical is part of my work... sexuality is not my field... (Sabrine).</i>			

Appendix sixteen

IRB approval forms: Phase I

RESEARCH COMMITTEE / INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL CHECKLIST

Date: July 7th, 2010

Applicant: Mathil Azar Degree: PhD student
Dept. / Division: Faculty of Health Sciences Rank: Lecturer

Co-Investigator(s): Dr Thilo Kroll as a research supervisor and Dr Caroline Bradbury Jones as an associate research supervisor.

Project Title: Understanding the experiences of middle-aged Lebanese women in disclosing sexual concerns and seeking help

Department Chairperson

The attached project is significant and is compatible with the academic programs of the Department:

Ursula Rizek U Rizek July 12, 2010
Name Signature Date

Faculty of Medicine Research Committee / I.R.B.

The attached project has been reviewed and approved:

Waila Zahed, PhD W Zahed 9.12.2010
Chairperson Signature Date

Medical Ethics Committee

The attached project has been reviewed and approved:

A. Carthage A Carthage 22-12-10
Chairperson Signature Date

Dean

The proposed research is consistent with the academic programs of the Faculty

Camille Nassar Camille Nassar 28/12/2010
Name Signature Date

Comments:

This is a true copy of the original document approving the above project by Institutional Research Board of the University of Balamand Faculty of Medicine and Medical Sciences in association with St. George Hospital University Medical Center on December 28, 2010.

Camille Nassar
Dr. Camille NASSAR
Dean
Faculty of Medicine and Medical Sciences
University of Balamand



November 23, 2016

مستشفى رفيق الحريري الجامعي



RAFIK HARIRI UNIVERSITY HOSPITAL

To: Ms Mathilde Azar, Principle Investigator
Dr Thio Kroll and Caroline Bradbury Jones, Co-Investigators
Faculty of Health and Science
University of Balamand

From: Wassim Nasreddine, MD
President of Institutional Review Board
Rafik Hariri University Hospital
Bir Hasan-Jnah, Lebanon

Subject: " Understanding the Experiences of Middle-aged Lebanese Women in Disclosing Sexual Concerns and Seeking Help"

Thank you for submitting to the Institutional Review Board (IRB) the above named proposal for review.

The IRB reviewed your letter, and the following documents on its meeting:

- Research Committee/Approval Checklist
- Participant Consent Form in Arabic

Thank you for submitting to the Institutional Review Board the above named proposal for review.

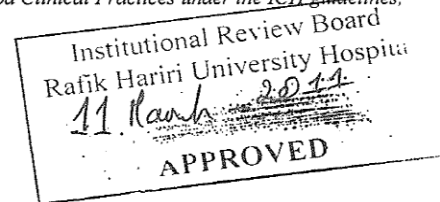
The IRB reviewed the letter and the above mentioned documents and would grant you approval to the study.

The membership of this Institutional Review Board complies with the membership requirements in the US Code of Federal Regulations (21CFR56 and 45CFR46) of the Food and Drug Administration.

In addition, the IRB operates in a manner consistent with Good Clinical Practices under the ICH guidelines, with FDA and applicable national /local regulations.

Sincerely,

W. Nasreddine
President of the IRB
Wassim Nasreddine



14/03/2011
Wassim Nasreddine

Appendix seventeen

IRB approval form: Phase II

RESEARCH COMMITTEE / INSTITUTIONAL REVIEW BOARD (IRB) APPROVAL CHECKLIST

Date: June 2013

Applicant: Mathilde Azar

Degree: PhD student

Dept. / Division: Nursing Programme, FHS, UOB

Rank: Lecturer

Co-Investigator(s) (Supervisors): Dr Thilo Kroll (Primary supervisor), Dr Carrie Bradbury-Jones & Pr. Mary Renfrew

Project Title: *Women's understandings of sexual problems and the pathways to help-seeking behaviour*

Department Chairperson

The attached project is significant and is compatible with the academic programs of the Department:

<i>Mathilde Azar</i>	<i>[Signature]</i>	<i>June 21, 2013</i>
Name	Signature	Date

Faculty Research Committee / I.R.B.

The attached project has been reviewed and approved:

<i>Latifa Zahed</i>	<i>[Signature]</i>	<i>1 Aug 2013</i>
Chairperson	Signature	Date

Medical Ethics Committee

The attached project has been reviewed and approved:

<i>Prof. Chawki Cortbaoui</i> Chirurgie Orthopédique	<i>[Signature]</i>	<i>02/10/12</i>
Chairperson	Signature	Date

Dean

The proposed research is consistent with the academic programs of the Faculty

<i>Camille Nassar</i>	<i>[Signature]</i>	<i>3/10/2013</i>
Name	Signature	Date

Comments:

This is a true copy of the original document approving the above project by Institutional Research Board of the University of Balamand Faculty of Medicine and Medical Sciences in association with St. George Hospital University Medical Center on October 3, 2013.

Camille Nassar
Dr. Camille NASSAR
Dean
Faculty of Medicine and Medical Sciences
University of Balamand



Appendix eighteen

IRB approval form of UREC



Academic & Corporate Governance

University of Dundee Research Ethics Committee

University of Dundee,
Dundee,
DD1 4HN.

25 November 2016

Dear Ms Azar

Retrospective Approval for study entitled: 'Middle-aged Lebanese women's construction of sexuality and sexual difficulties: A multiphase qualitative inquiry'

I have reviewed the documentation pertaining to IRB approval of two research proposals submitted as part of your PhD studies.

The authenticity of the approved documentation has been confirmed by the Dean of Faculty of Medicine and Medical Sciences at the University of Balamand.

In the circumstances, I am prepared to agree to retrospective approval of the research undertaken.

Yours sincerely,

A handwritten signature in cursive script that reads 'Elizabeth Hannah'.

Dr Elizabeth Hannah
Convener, University of Dundee Research Ethics Committee

Cc Dr Andrew Symon
Professor Thilo Kroll
Professor Margaret Smith
Dr Clive Randall



Appendix nineteenth

Information sheet and informed consent form addressed to women: Phase I

Title of the study: *Understanding the experiences of middle-aged Lebanese women in disclosing sexual concerns and seeking help*

Researcher: Mathil Azar

Participant pseudonym:

a. Information sheet

Purpose: You have been invited to participate in a research study that aims at exploring the meaning of disclosing sexual concerns of middle-aged Lebanese women and understanding what factors determine their decision to seek help when sexual concerns arise. This study is conducted by the researcher Mathil Azar based at the University of Balamand. The study forms part of her PhD education at the University of Dundee. The generated results will help improve women's sexual health.

You are being invited to take part in this research as a client of the Mammography unit from which women who meet the inclusion criteria of the study are selected or as a friend of one of the participants. We believe that your experience as a mature woman can contribute much to our understanding and knowledge of female sexuality around the age of menopause, 40 - 55 years.

Procedure: If you agree to participate in the study, you will be asked to participate in a one-time interview (or focus group discussion), which will last up to 90 minutes. During the interview, I will sit down with you alone (or with a group of women) in a comfortable place at either in the centre or at your home. The interview will be audio-recorded, but you will not be identified by your name in any documents that report study findings. Your name will be replaced by a pseudonym.

Risks and benefits: There are no foreseeable risks to you related to the study. Based on the generated results, we hope that the benefits will be reflected by the initiation of awareness and sensitization programs to improve women's sexuality.

Confidentiality: All collected information will be kept confidential. Original data will be shared only with the PhD supervisors and the translator, knowing that pseudonyms will be used. It will also be securely stored and locked up by the researcher (myself).

Researcher safety: To ensure the researcher safety in case she will meet you at home to conduct the interview, your address will be confidentially kept in a sealed envelope with a

colleague at work. In case the researcher does not comeback after the estimated duration of the interview and does not answer her mobile phone, the colleague will be notified to open the envelope and contact you to inquire about the researcher.

Withdrawal: Your participation in this study is voluntary. You may withdraw your consent at any time without any prejudice. It will not affect in any way the care and clinical support you are receiving. At the end of the interview, I will brief you on the most important points of your accounts, and you can ask to change some ideas to make them clearer or to completely remove other ideas.

Sharing research finding: The research findings will be published at the national and international levels. At the same time, different conferences will be organized for the concerned communities, women, couples, health professionals, to raise awareness based on the results of the study in order to initiate corrective measures. A brief summary of study findings may be sent to you upon request.

Contact information: If you have any further questions about the study or about your rights as a participant, please contact the researcher Mathil Azar, at University of Balamand, Faculty of Health Sciences, Tel. 01.562108/9. Fax: 01 562110. You may also refer to the primary research supervisor Dr Thilo Kroll who is accessible on the following email: t.kroll@dundee.ac.uk

b. Certificate of consent:

I, -----, the participant who met the inclusion criteria of the study, have read (or it has been read to me) and understood all written materials which have been provided to me, further describing the study and potential risks and benefits related to my participation.

I have been given the opportunity to ask any questions concerning my engagement in the study and all such questions have been answered to my complete satisfaction. I understand that my participation in this study is voluntary and can be terminated at any time upon my request without prejudice. I agree for the audio recordings of the interviews and report direct quotations arising out of the interviews. I also understand that if I have any further problems or questions I should contact the above named researcher of the study Mathil Azar.

When the participant does not have formal education, a literate witness will ascertain that the informed consent was understood and was given freely. In this case, the witness and the researcher sign under the following:

I have read or witnessed the reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that consent was given freely.

Participant's name	-----	Signature	-----
Witness' name	-----	Signature	-----
Researcher's name	-----	Signature	-----
Date	-----		

Appendix twenty

Information sheet and informed consent form addressed to women: Phase II-B

Title of the study: *Women's understandings of sexual problems and the pathways to help-seeking behaviour*

Researcher: *Mathil Azar*

Participant pseudonym:

a. Information sheet

Purpose: You have been invited to participate in a research study that aims to explore women's understandings of sexual problems and help-seeking behaviour. This study is conducted by the researcher Mathil Azar based at the University of Balamand as part of her PhD education at the University of Dundee, Scotland, UK. The generated findings are expected to contribute to the improvement of women's sexual health.

You are being invited to take part in this research because you are a client of the OB/GYN clinic from which women who meet the inclusion criteria of the study are selected (or because you were proposed by one of the participants). We believe that your experience as a mature woman can contribute much to our understanding and knowledge of female sexuality around the age of menopause, 40 - 55 years.

Procedure: If you agree to take part in the study, you will be asked to participate in a one-time individual interview or focus group of six to eight women, lasting approximately 60 to 90 minutes. The encounter will be held in a comfortable place either in the centre, researcher workplace or your home. The talk will be audio-recorded. You will not be identified by name neither on the audio-recorder nor in any documents that report study findings. Your name will be replaced by a pseudonym.

Risks and benefits: There are no foreseeable risks to you related to the study. Based on the generated results, we hope that the benefits will be reflected by the initiation of awareness and sensitisation programs to improve women's sexual health.

Confidentiality: All collected information will be kept confidential using pseudonyms and will be securely stored and locked up by the researcher. Some transcripts will be translated into English language and shared with the PhD supervisors.

Researcher safety: To ensure researcher safety in case the interview will be conducted at home, your address will be confidentially kept in a sealed envelope with a colleague at work. In case the researcher does not come back after the estimated duration of the interview and does not answer her mobile phone, the colleague will be notified to open the envelope and contact you to inquire about her.

Withdrawal: Your participation in this study is voluntary. You may withdraw your consent at any time without any prejudice. At the end of the interview, the researcher will brief you on the most important points of your talk or discussion, and you can ask to change some ideas to make them clearer or to completely remove other ideas.

Sharing research finding: The research findings will be published at the national and international levels. At the same time, different conferences will be organised with women, couples and professionals to raise awareness and promote sexual health. A brief summary of findings may be sent to you upon request.

Contact information: If you have any further questions about the study or about your rights as a participant, please contact the researcher Mathil Azar, at the University of Balamand, Faculty of Health Sciences, Tel. 01.562108/9. You may also refer to the primary research supervisor Dr Thilo Kroll who is accessible on the following email: t.kroll@dundee.ac.uk

b. Certificate of consent:

I, -----, the participant who met the inclusion criteria of the study, have read (or it has been read to me) and understood all written materials which have been provided to me, further describing the study and potential risks and benefits related to my participation.

I have been given the opportunity to ask any questions concerning this procedure and all such questions have been answered to my complete satisfaction. I understand that my participation in this study is voluntary and can be terminated at any time upon my request without prejudice. I also understand that if I have any further problems or questions I should contact the above named researcher of the study Mathil Azar.

When the participant does not have formal education, a literate witness will ascertain that the informed consent was understood and was given freely. In this case, the witness and the researcher sign under the following:

I have read or witnessed the reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that consent was given freely.

Participant's name -----	Date -----
Witness name -----	Date -----
Researcher name -----	Date -----

Appendix twenty one

Information sheet and informed consent form addressed to nurses and midwives: Phase II-B

Title of the study: *Women's understandings of sexual problems and the pathways to help-seeking behaviour*

Researcher: *Mathil Azar*

Participant pseudonym:

a. Information sheet

Purpose: You have been invited to participate in a research study that aims to explore women's understandings of sexual problems and help-seeking behaviour. This study is conducted by the researcher Mathil Azar based at the University of Balamand as part of her PhD education at the University of Dundee, Scotland, UK. The generated findings are expected to contribute to the improvement of women's sexual health.

You are being invited to take part in this research because you are a nurse or midwife who works in this healthcare centre and who meets the inclusion criteria of the study. You are requested to discuss your perceptions and experiences concerning nurses' and midwives' role in sexuality-related care. We believe that your experience can contribute to our understanding and knowledge of female sexuality around the age of menopause, 40 - 55 years and your role at this level.

Procedure: If you agree to take part in the study, you will be asked to participate in a focus group of six to eight nurses and midwives that will take approximately 90 minutes. The encounter will be held in a comfortable place either in the centre or the researcher workplace. The discussion will be audio-recorded. You will not be identified by name neither on the tape nor in any documents that report study findings. Your name will be replaced by a pseudonym.

Risks and benefits: There are no foreseeable risks to you related to the study. Based on the generated results, we hope that the benefits will be reflected by the initiation of awareness and sensitisation programs to improve women's sexual health.

Confidentiality: All collected information will be kept confidential using pseudonyms and will be securely stored and locked up by the researcher. Some transcripts will be translated into English language and shared with the PhD supervisors.

Withdrawal: Your participation in this study is voluntary. You may withdraw your consent at any time without any prejudice. At the end of the interview, the researcher will brief you on the most important points of your talk or discussion, and you can ask to change some ideas to make them clearer or to completely remove other ideas.

Sharing research finding: The research findings will be published at the national and international levels. At the same time, different conferences will be organised with women, couples and professionals to raise awareness and promote sexual health. A brief summary of findings may be sent to you upon request.

Contact information: If you have any further questions about the study or about your rights as a participant, please contact the researcher Mathil Azar, at the University of Balamand, Faculty of Health Sciences, Tel. 01.562108/9. You may also refer to the primary research supervisor Dr Thilo Kroll who is accessible on the following email: t.kroll@dundee.ac.uk

b. Certificate of consent:

I, -----, the participant who met the inclusion criteria of the study, have read (or it has been read to me) and understood all written materials which have been provided to me, further describing the study and potential risks and benefits related to my participation.

I have been given the opportunity to ask any questions concerning this procedure and all such questions have been answered to my complete satisfaction. I understand that my participation in this study is voluntary and can be terminated at any time upon my request without prejudice. I also understand that if I have any further problems or questions I should contact the above named researcher of the study Mathil Azar.

Participant name: ----- Date: -----
 Researcher name ----- Date: -----

Appendix twenty two

Table III. Description of the sample of women

Pseudonym	Age	Marital status	Education level	Occupation	Religion	Menopausal status
Phase I						
Individual Interviews						
Asma	44	Married	University	Lecturer	Christian	Premenopause
Beatrice	54	Married	Secondary	Housewife	Christian	Menopause
Chaten	50	Widowed	Secondary	Housewife	Christian	Perimenopause
Dima	48	Married	University	Laboratory technician	Muslim	Perimenopause
Elham	40	Divorced	Secondary	Vendor	Muslim	Premenopause
Fadwa	47	Single	Secondary	Accounting	Christian	Premenopause
Gihane	43	Married	Intermediate	Housewife	Christian	Premenopause
Hana	50	Married	Secondary	Housewife	Muslim	Menopause
Inass	42	Married	University	Radiology	Muslim	Premenopause
Jana	48	Married	Intermediate	Housewife	Muslim	Perimenopause
Karine	43	Married	Elementary	Housewife	Muslim	Premenopause
Lana	50	Married	Secondary	Housewife	Christian	Perimenopause
May	49	Widowed	Intermediate	Housewife	Muslim	Perimenopause
Nada	48	Married	Intermediate	Vendor	Muslim	Premenopause
Oumaya khawla	46	Married	Intermediate	Housewife	Muslim	Premenopause
	55	Married	No formal education	Housewife	Muslim	Menopause
Quinda	41	Married	Secondary	Housewife	Christian	Premenopause
Rama	40	Married	No formal education	Housewife	Christian	Premenopause

Confirmatory Focus Group

Sawsan	55	Married	Elementary	Housewife	Muslim	Menopause
Najat	47	Married	Secondary	Housewife	Muslim	Premenopause
Uguette	54	Married	Secondary	Cook	Christian	Menopause
Valia	44	Married	No formal education	Housekeeper	Christian	Premenopause
Widad	40	Married	Secondary	Manager	Christian	Premenopause

Phase II-A

Individual Interviews

Adèle	54	Married	University	Secretary	Christian	Menopause
Bahjat	54	Married	Elementary	Housewife	Christian	Menopause
Carmen	43	Married	University	Psychologist	Christian	Premenopause
Dalia	46	Married	University	Hair dresser	Christian	Premenopause
Elsie	50	Widowed	Intermediate	Secretary	Muslim	Premenopause
Faten	48	Married	University	Dentist	Christian	Menopause
Gaby	44	Married	Intermediate	Liberal	Christian	Premenopause
Hasmig	43	Married	Elementary	Vendor	Christian	Premenopause
Ibtissam	53	Married	University	Instructor	Muslim	Menopause
Jamal	49	Married	University	Instructor	Muslim	Premenopause
Kamal	55	Married	University	Instructor	Muslim	Menopause
Lea	48	Married	University	Monitor	Muslim	Premenopause
Mada	46	Married	Intermediate	Housewife	Muslim	Menopause
Nay	52	Married	Intermediate	Housewife	Muslim	Menopause
Odile	49	Married	Intermediate	Housewife	Christian	Premenopause
Pamela	48	Married	Secondary	Housewife	Christian	Premenopause
Quinana	40	Married	Intermediate	Housewife	Christian	Menopause
Rayan	45	Married	Elementary	Housewife	Christian	Premenopause
Sara	49	Married	Elementary	Housewife	Muslim	Premenopause

Focus Group I

Raja	42	Married	University	Life coach	Muslim	Premenopause
Jeanne	52	Married	Secondary	Housewife	Christian	Perimenopause
Nadege	47	Married	University	Housewife	Christian	Premenopause
Mirvat	41	Married	University	Journalist	Muslim	Premenopause
Tamara	49	Married	University	Journalist	Muslim	Perimenopause
Zeina	52	Married	Secondary	Sale manager	Christian	Menopause

Focus Group II

Tressy	45	Married	Intermediate	Housewife	Christian	Premenopause
Sally	49	Married	University	Housewife	Muslim	Perimenopause
Razan	43	Married	Elementary	Housewife	Muslim	Premenopause
Racha	51	Married	Secondary	Housewife	Christian	Menopause